S. HRG. 108–585

PROPOSED FISCAL YEAR 2004 BUDGET FOR VETERANS' PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

FEBRUARY 26, 2003

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FEBRUARY 26, 2003

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PROPOSED FISCAL YEAR 2004 BUDGET FOR VETERANS' PROGRAMS

WEDNESDAY, FEBRUARY 26, 2003

UNITED STATES SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 4:05 p.m., in room SR–418, Russell Senate Office Building, Hon. Arlen Specter, (chairman of the committee), presiding.

Present: Senators Specter, Bunning, Akaka, Nelson, and Jeffords.

OPENING STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Chairman SPECTER. Good afternoon, ladies and gentlemen. The hearing on the proposed fiscal year 2004 budget for veterans programs will now commence.

Our distinguished Ranking Member, Senator Bob Graham, had expected to be with us today, but is not quite ready for the rigors of Secretary Principi.

[Laughter.]

I think he made a wise judgment. I had some doubts about attending this hearing myself.

[Laughter.]

This is in a very serious vein, a very, very serious hearing. Our obligation to America's veterans is very, very major. This is especially so at a time when war is imminent and we will be putting 200,000, or perhaps more American troops, men and women, into harm's way. And we enjoy the greatest country in the history of the world and democracy because of the sacrifices which have been made by men and women who have served in the military since the Revolutionary War and before.

As I have said with some frequency from this position, and will say as long as I have this position, the first veteran I knew was my father, Harry Specter, who was wounded in action in the Argonne Forest, carried shrapnel in his legs until the day he died, and was not treated fairly by the United States Government. They promised the veterans a bonus, and they broke the promise. And that has regrettably been a too-frequent pattern.

And the veterans marched in Washington. And today, when there is a demonstration, they roll out the red carpet. Then, they rolled out the cavalry with drawn sabers, led by Major George C. Patton under the command of the Chief-of-Staff, General Douglas

MacArthur, who was getting advice from his aide-de-camp, Major Dwight Eisenhower.

And they shot and killed veterans that day, one of the blackest days in American history. And I say—in a metaphorical sense—that I have been on my way to Washington ever since to get my father's bonus. Since I haven't gotten it yet, I am still working at it.

The budget hearing we have today is a very important one. We will cover a lot of tough issues which face the Veterans Administration. The total request for fiscal year 2004 is $60.723 billion. And the needs are enormous.

What we will consider today are a number of the policy proposals which the VA has stated an intention to adopt administratively: the suspension of enrollment of so-called Priority 8 veterans, and increased outpatient care co-payments.

A number of proposals require legislation: discontinuance of authority to provide nursing home care to more than 70 percent service-connected vets, with a grandfather provision; a proposed annual enrollment fee of $250 per year for veterans with incomes over $24,644 a year; an increase in pharmacy co-payments; and authorizing the VA to collect reimbursements from PPO's and HMO's, not just from fee-for-service insurers.

Now, the committee welcomes the very distinguished Secretary of Veterans Affairs, the Honorable Anthony J. Principi. And the floor is yours, Mr. Secretary.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY OF VETERANS AFFAIRS, ACCOMPANIED BY ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH; DANIEL L. COOPER, UNDER SECRETARY FOR BENEFITS; ERIC BENSON, ACTING UNDER SECRETARY FOR MEMORIAL AFFAIRS; TIM McCLAIN, GENERAL COUNSEL; AND WILLIAM H. CAMPBELL, ASSISTANT SECRETARY FOR MANAGEMENT

Secretary PRINCIPI. Thank you, Mr. Chairman. And I was taken by the story about your father, and you talked about the Bonus March of 1915, and I am reminded that the Congress of the United States——

Chairman SPECTER. It was 1932, Mr. Secretary.

Secretary PRINCIPI. 1932. The Congress, remembering the events of that Bonus March, came back and passed one of the most successful pieces of legislation in the history of our country, the GI Bill of 1944, for the demobilizing of 16 million men and women of World War II and the education and the housing programs administered by the VA back then, which helped to build modern America.

But now we are in 2003. And first, before going to 2004, I want to thank you, Mr. Chairman, for your advocacy and for your help on the Appropriations Committee for allowing the VA to receive a very, very sizable increase this year, just signed into law yesterday. We all regret it could not have been sooner, but we did yesterday get one of the largest increases in health care, $2.6 billion, over 2002.

And that increase, along with the other increases in discretionary spending, will allow the agency to begin the important task of

ramping up so we can eliminate this backlog of veterans who are on waiting lists to see their primary care physician or their specialist.

And so, I thank you, Mr. Chairman, the members of this committee, and the members of the Appropriations Committee for adding to the President's request, which, in and of itself, for 2003 was a record increase. But your $1.1 billion add-on will dramatically help us.

I am very, very proud of the budget we are submitting in 2004. I have never misled the committee to say that it is all that we need. But it is a sizable increase for the VA: a 7.7 percent increase in discretionary spending; 8 percent increase in health care, the largest percentage increase of any agency of the Federal Government at a time of enormous fiscal constraint.

In health care, it is a $2 billion increase, Mr. Chairman, $1.5 billion in new revenues appropriations and an additional $500 million in co-payments, increased co-payments, and collections from insurance companies. And I believe that is the largest increase ever requested for VA health care, and we believe it will go a long way to meeting the health care needs for 2004.

But when Congress enacted open enrollment, Mr. Chairman, in 1998, the growth in the demand for health care for the VA has been somewhat out of control, if you will. The demand has been very, very profound and very significant. Last year, we enrolled an additional 830,000 veterans in the VA health care system.

In 1998, we were caring for about 2.9 million veterans. Today, we have 6.8 million enrolled. Well over 4 million of those 6.8 million veterans are users. And we have had to make some tough choices notwithstanding the sizable increase.

As you know, I have suspended enrollment for Category 8. Congress directed that I make an annual enrollment decision, and I felt that the growth and the waiting lists dictated that I do that.

And we need to focus on our core constituency, the men and women disabled in the service of our country, those who are poor and have few other options, and to ensure that we maintain our leading edge in specialized care: spinal cord injury, blind rehabilitation, mental health, and other fields as well.

Accordingly, we have proposed an increase in co-payments for those who are most capable of defraying an increased portion of their care, an annual enrollment fee. But at the same time, we have eliminated the co-payments for pharmaceuticals for the veterans at the lowest end, those who are truly poor, by raising the threshold from $9,000 a year, which is obviously at the very, very low end, to $16,000 a year.

So although we are asking that those who have higher incomes to defray an increased percentage, we are also eliminating the co-pays for the poorest of the poor.

In the National Cemetery System, we have the most aggressive schedule of opening new cemeteries since the Civil War. We are proposing to open up four new cemeteries over the next several years. A fifth in Sacramento will follow shortly thereafter.

On the benefits side, the budget that we proposed will allow us to continue to bring down the backlog of veterans who are waiting

for disability claims and pensions, and we are well on our way to achieving that goal as well by October of this new fiscal year.

So all in all, Mr. Chairman, I think we have presented to you a good budget. But it is one that will require us to tighten our belts and to find more efficiencies in our system so that we can continue to provide high-quality, timely care, again, to those core constituencies of our disabled, our poor, and those in need of specialized services.

I am accompanied, sir, by Tim McClain on my far left, our General Counsel; Bill Campbell, our Assistant Secretary of Management; Dr. Bob Roswell, our Under Secretary of Health; Admiral Dan Cooper, our Under Secretary of Benefits; and Eric Benson, our Acting Under Secretary of Memorial Affairs.

Thank you, Mr. Chairman.

[The prepared statement of Secretary Principi follows:]

PREPARED STATEMENT OF THE HON. ANTHONY J. PRINCIPI, SECRETARY OF VETERANS AFFAIRS

Mr. Chairman and members of the Committee, good morning. I am pleased to be here today to present the President's 2004 budget proposal for the Department of Veterans Affairs (VA). The centerpiece of this budget is our strategy to bring balance back to our health care system priorities. I have by my decisions and by my actions focused VA health care on veterans in the highest statutory priority groups—the service-connected, the lower income, and those veterans who need our specialized services. This budget reflects those priorities.

The President's 2004 budget request totals $63.6 billion—$33.4 billion for entitlement programs and $30.2 billion for discretionary programs. This represents an increase of $3.3 billion, which includes a 7.7 percent rise in discretionary funding, over the enacted level for 2003, and supports my three highest priorities:

- Sharpen the focus of our health care system to achieve primary care access standards that complement our quality standards;
- Meet the timeliness goal in claims processing;
- Ensure the burial needs of veterans are met, and maintain national cemeteries as shrines.

Virtually all of the growth in discretionary resources will be devoted to VA's health care system. Including medical care collections, funding for medical programs rises by $2.0 billion. As a key component of our medical care budget, we are requesting $225 million to begin the restructuring of our infrastructure as part of the implementation of the Capital Asset Realignment for Enhanced Services (CARES) program.

We are presenting our 2004 request using a new budget account structure that more readily presents the funding for each of the benefits we provide veterans. This will allow the Department and our stakeholders to more effectively evaluate the program results we achieve with the total resources associated with each program.

MEDICAL CARE

The President's 2004 budget includes $27.5 billion for medical care, including $2.1 billion in collections, and represents an 8.0 percent increase over the enacted level for 2003. These resources will ensure we can provide health care for over 4.8 million unique patients in 2004.

The primary reason VA exists is to care for service-connected disabled veterans. They have made enormous sacrifices to help preserve freedom, and many continue to live with physical and psychological scars directly resulting from their military service to this Nation. Every action we take must focus first and foremost on their needs. In addition, our primary constituency includes veterans with lower incomes and those who have special health care needs. By sharpening the focus of our health care system on these core groups, we will be positioned to achieve our primary care access standards.

The demand for VA health care has risen dramatically in recent years. From 1996 to 2002, the number of patients to whom we provided health care grew by 54 percent. Among veterans in Priority Groups 7 and 8 alone, the number treated in 2002 was about 11 times greater than it was in 1996. The combined effect of several factors has resulted in this large increase in the demand for VA health care services.

First, the Veterans Health Care Eligibility Reform Act of 1996 and the Veterans Millennium Health Care Act of 1999 opened the door to comprehensive health care services to all veterans. Second, the national reputation and public perception of VA as a leader in the delivery of quality health care services has steadily risen, due in part to widespread acknowledgement of our major advances in quality and patient safety. Third, access to health care has greatly improved with the opening of hundreds of community-based outpatient clinics. Fourth, our patient population is growing older and this has led to an increase in veterans' need for health care services. Fifth, VA has favorable pharmacy benefits compared to other health care providers, especially Medicare, and this has attracted many veterans to our system. And finally, some feel that public disenchantment with Health Maintenance Organizations, along with their economic failure, may have caused many patients to seek out established and traditional sources of health care such as VA. All of these factors have put a severe strain on our ability to continue to provide timely, high-quality health care, especially for those veterans who are our core mission.

Through a combination of proposed regulatory and legislative changes, as well as a request for additional resources, our 2004 budget will help restore balance to our health care system priorities and ensure we continue to provide the best care possible to our highest priority veterans. The most significant changes presented in this budget are to:

- Assess an annual enrollment fee of $250 for non-service-connected Priority 7 veterans and all Priority 8 veterans;
- Increase co-payments for Priority 7 and 8 veterans for outpatient primary care from $15 to $20 and for pharmacy benefits from $7 to $15;
- Eliminate the pharmacy co-payment for Priority 2-5 veterans whose income is below the pension aid and attendance level of $16,169;
- Expand non-institutional long-term care with reductions in institutional care in recognition of patient preferences and the improved quality of life possible in non-institutional settings.

Revolutionary advances in medicine moved acute medical care out of institutional beds and rendered obsolete "bed count" as a measure of health care capacity. The same process is underway in long-term care and this budget proposes to focus VA's long-term care efforts on increased access to long-term care for veterans, rather than counting institutional beds. This budget focuses long-term care on the patient and his or her needs. Our policies expand access to non-institutional care programs that will allow veterans to live and be cared for in the comfort and familiar setting of their home surrounded by their family.

While we will shift our emphasis to non-institutional forms of long-term care, we will continue to provide institutional long-term care to veterans who need it the most—veterans with service-connected disabilities rated 70 percent or greater and those who require transitional, post-acute care. Coupled with this, our budget continues strong support for grants for State nursing homes.

In addition, we are working with the Department of Health and Human Services to implement the plan by which Priority 8 veterans aged 65 and older, who cannot enroll in VA's health care system, can gain access to a new "VA+Choice Medicare" plan. This would allow for these veterans to be able to use their Medicare benefits to obtain care from VA. In return, we would receive payments from a private health plan contracting with Medicare to cover the cost of the health care we provide. The "VA+Choice Medicare" plan will become effective later this year as the two Departments finalize the details of the plan.

Coupled with my recent decision on enrollment, these proposed regulatory and legislative changes would help ensure that sufficient resources will be available to provide timely, high-quality health care services to our highest priority veterans. If these new initiatives are implemented, veterans comprising our core mission population will account for 75 percent of all unique patients in 2004, a share noticeably higher than the 67 percent they held in 2002. During 2004, we will treat 167,000 more veterans in Priority Groups 1-6 (those with service-connected disabilities, lower-income veterans, and those needing specialized care).

In return for the resources we are requesting for the medical care program, we will be able to build upon our noteworthy performance achievements during the past 2 years. During 2002, VA received national recognition for its delivery of high-quality health care from the Institute of Medicine in the report titled "Leadership by Example." In addition, the Department received the Pinnacle Award from the American Pharmaceutical Association Foundation in June 2002 for its creation of a bar code medication administration system. This important patient safety initiative ensures that the correct medication is administered to the correct patient at the proper time. Patient satisfaction rose significantly last year, as 7 of every 10 inpatients and outpatients rated VA health care service as very good or excellent.

We will continue to use clinical practice guidelines to help ensure high-quality health care, as they are directly linked with improved health outcomes. We will employ this approach most extensively in the management of chronic disease and in disease prevention. For 16 of the 18 quality-of-care indicators for which comparable data from managed care organizations are available, VA is the benchmark, exceeding the best competitor's performance.

Mr. Chairman, one of our most important focus areas in our 2004 budget is to significantly reduce waiting times, particularly for patients who are using our health care system for the first time. As we begin to rebalance our health care system with a heightened emphasis on our core service population, we will drive down waiting times. By 2004, VA will achieve our objective of 30 days for the average waiting time for new patients seeking an appointment at a primary care clinic. In addition, we have set a performance goal of 30 days for the average waiting time for an appointment in a specialty clinic. With this budget and the enacted funding level for 2003, we will eliminate the waiting list by the end of 2003.

We remain firmly committed to managing our medical care resources with increasing efficiency each year. The 2004 budget includes management savings of $950 million. These savings will partially offset the need for additional funds to care for an aging patient population that will require an ever-increasing degree of health care service, and rising costs associated with a sharply growing reliance on pharmaceuticals necessary to treat patients with complex, chronic conditions. We will achieve these management savings by implementing a rigorous competitive sourcing plan, reforming the health care procurement process, increasing employee productivity, increasing VA/DoD sharing, continuing to shift from inpatient care to outpatient care, and reducing requirements for supplies and employee travel.

Our projection of medical care collections for 2004 is $2.1 billion. This total is 32 percent above our estimated collections for 2003 and will nearly triple our 2001 collections. By implementing a series of aggressive steps identified in our revenue cycle improvement plan, we are already making great strides towards maximizing the availability of health care resources. For example, we have mandated that all medical facilities establish patient pre-registration to include the use of software that assists in gathering and updating information on patient insurance. We are in the midst of a series of pilot projects at four Veterans Integrated Service Networks to test the implementation of a new business plan that calls for reconfiguration of the revenue collection program by using both in-house and contract models. In addition, the Department will award the Patient Financial Services System this spring to Network 10 (Ohio) which will acquire and deploy a commercial system of this type. This project involves comprehensive implementation of standard business practices and information technology improvements.

As you know Mr. Chairman, one of the President's management initiatives calls for VA and the Department of Defense (DoD) to enhance the coordination of the delivery of benefits and service to veterans. Over the past year, our two Departments have undertaken unprecedented efforts to improve cooperation and sharing in a variety of areas through a Joint Executive Council (JEC). To expand the scope of interdepartmental cooperation, a benefits committee has been added to complement the longstanding Health Executive Council. The VA and DoD Benefits Executive Council is exploring improved transfer and access to military personnel records and a pilot project for a joint physical examination to improve the claims process for military personnel. The JEC provides overarching policy direction, sets strategic vision and priorities for the health and benefits committees, and serves as a forum for senior leaders to oversee coordination of initiatives. To address some of the remaining challenges, the Departments have identified numerous high-priority items for improved coordination such as the joint strategic mission and planning process, computerized patient medical records, eligibility and enrollment systems, joint separation physicals and compensation and pension examinations, and a joint consolidated mail-out pharmacy pilot.

CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES (CARES)

The 2004 budget includes $225 million of capital funding to move forward with the Capital Asset Realignment for Enhanced Services (CARES) initiative. This program addresses the needed infrastructure realignment for the health care delivery system and will allow the Department to provide veterans with the right care, at the right place, and at the right time. CARES will assess veterans' health care needs across the country, identify delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets so that we can optimize health care delivery in terms of both quality and access.

As demonstrated in Veterans Integrated Service Network 12, restructuring will require significant investment to achieve a system that is appropriately sized for our future. Our preliminary estimate for resources that can be redirected to medical care between now and 2010 as a result of the appropriate alignment of assets and health care services, and the sale or enhanced-use leasing of underutilized or nonperforming assets, is $6.8 billion. It is extremely important to have funding in 2004 to begin the multiyear effort to restructure. Given the timing associated with identifying CARES projects, we will be working with your committee on the authorization process in order not to delay the start of these projects.

MEDICAL AND PROSTHETIC RESEARCH

Mr. Chairman, we are requesting $822 million in funding for VA's clinical research program, an increase of 3.4 percent from the 2003 level. For the first time, our request includes funds in the form of salary support for clinical researchers, resources that previously were a component of the Medical Care request. This approach provides a more complete picture of VA's resources devoted to this program. In addition to the Department's funding request, nearly $700 million in funding support comes from other federal agencies such as DoD and the National Institutes of Health, as well as universities and other private institutions.

This $1.5 billion will support more than 2,700 high-priority research projects to expand knowledge in areas critical to veterans' health care needs—Gulf War illnesses, diabetes, heart disease, chronic viral diseases, Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, women's health care concerns, and rehabilitation programs.

VETERANS BENEFITS

The Department's 2004 budget request includes $33.7 billion for the entitlement and discretionary costs supporting the six business lines administered by the Veterans Benefits Administration (VBA). Within this total, $1.17 billion is included for the management of these programs—compensation; pension; education; vocational rehabilitation and employment; housing; and insurance.

Improving the timeliness and accuracy of claims processing is a Presidential priority, and during the last year we have made excellent progress toward achieving this goal. A year ago, I testified that I had set a performance goal of processing compensation and pension claims in an average of 100 days by the summer of 2003. I am pleased to report that we are on target to meet that goal and we will maintain that improved timeliness standard for 2004. When we reach this goal, we will have reduced the time it takes to process claims by more than 50 percent from the 2002 level.

At the same time that we are improving timeliness, we will be increasing the accuracy of our claims processing. The 2004 performance goal for the national accuracy rate is 90 percent, a figure 10 percentage points higher than last year's level of performance, and markedly above the accuracy rate of 59 percent in DoD.

The driving force that will allow us to make this kind of progress with only a slight budget increase continues to be the initiatives we are implementing from the Claims Processing Task Force I established in 2001. Located at the Cleveland Regional Office, our Tiger Team has been working over the last year to eliminate the backlog of claims pending over 1 year, especially for veterans 70 years of age or older. This aggressive effort of reducing the backlog and improving timeliness is underway at all of our regional offices. VBA has established specialized processing teams, such as triage, pre-determination, rating, post-determination, appeals, and public contact. Other Task Force initiatives, such as changing the procedure for remands, revising the time requirements for gathering evidence, and consolidating the maintenance of pension processing at three sites, have allowed us to free up resources to work on direct processing at the regional offices.

This budget includes additional staff and resources for new and ongoing information technology projects to support improved claims processing. We are requesting $6.7 million for the Virtual VA project that will replace the current paper-based claims folder with electronic images and data that can be accessed and transferred electronically through a web-based solution. We are seeking $3.8 million for the Compensation and Pension Evaluation Redesign, a project that will result in a more consistent claims examination process. In addition, we are requesting $2.6 million in 2004 for the Training and Performance Support Systems, a multi-year initiative to implement five comprehensive training and performance support systems for positions critical to the processing of claims.

In support of the education program, the budget proposes $7.4 million for continuing the development of the Education Expert System. These resources will be

used to expand upon an existing prototype expert system and will enable us to automate a greater portion of the education claims process and expand enrollment certification. This initiative will contribute toward achievement of our 2004 performance goal of reducing the average time it takes to process claims for original and supplemental education benefits to 27 days and 12 days, respectively.

VA is requesting $13.2 million for the One-VA Telephone Access project, an initiative that will support all of VBA's benefits programs. This initiative will result in the development of a Virtual Information Center that forms a single telecommunications network among several regional offices. This technology will allow us to answer calls at any place and at any time without complex call routing devices.

All of these information technology projects are consistent with the Department's Enterprise Architecture and will be supported by improved project administration from our Chief Information Officer.

BURIAL

The President's 2004 budget includes $428 million for VA's burial program, which includes operating and capital funding for the National Cemetery Administration (NCA), the burial benefits program administered by VBA, and the State Cemetery Grant program. This total is $17 million, or 4.1 percent, over the 2003 level.

This budget request includes $4.3 million for the activation and operation of five new national cemeteries in 2004. NCA plans to open fast-track sections for interments at four new national cemeteries planned for Atlanta, South Florida, Pittsburgh, and Detroit. Fort Sill National Cemetery opened a small, fast-track section for interments in November 2001, and Phase 1 construction of this cemetery should be complete by June 2003. In addition to resources for these five new cemeteries, this budget request also includes resources to prepare for the future opening of a fast-track section of an additional national cemetery near Sacramento. The locations of these national cemeteries were identified in a May 2, DoD report to Congress as the six areas most in need of a new national cemetery.

With the opening of these new cemeteries, VA will increase the proportion of veterans served by a burial option within 75 miles of their residence to nearly 82 percent.

The $108.9 million in construction funding for the burial program in 2004 includes resources for Phase 1 development of the Detroit cemetery, expansion and improvements at cemeteries in Fort Snelling, Minnesota and Barrancas, Florida, as well as $32 million for the State Cemetery Grant program.

The budget request includes $10 million to support the Department's commitment to ensuring that the appearance of national cemeteries is maintained in a manner befitting a national shrine. One of the key performance goals for the burial program is that 98 percent of survey respondents rate the appearance of national cemeteries as excellent.

A new performance measure established for NCA is marking graves in a timely manner after interment. We have established a 2004 performance goal of marking 75 percent of graves in national cemeteries within 60 days of interment. When we achieve this goal, it will represent a dramatic improvement over the 2002 level of 49 percent.

MANAGEMENT IMPROVEMENTS

Mr. Chairman, we have made excellent progress during the last year in implementing, or developing, several management initiatives that address our goal of applying sound business principles to all of the Department's operations. We are particularly pleased with our accomplishments in addressing the President's Management Agenda that focuses on strategies to improve the management of the Federal government in five areas—human capital; competitive sourcing; financial performance; electronic government; and budget and performance integration.

We have developed a sound workforce and succession plan that includes strategies VA will pursue to implement a more corporate approach to human capital management, and a workforce analysis of several of the Department's critical positions—physicians, nurses, and compensation and pension veterans service representatives. We are moving forward with a competitive sourcing study of our laundry service, and other studies will be conducted of our pathology and laboratory services, and facilities management and operations. With regard to financial performance, we achieved an unqualified audit opinion for the fourth consecutive year. During 2003 and 2004, we will be involved in 10 electronic government studies. And finally, we continue to progress in our efforts to better integrate resources with results. One major accomplishment in this area is the restructuring of our budget accounts. This

new account structure is presented in our 2004 budget and will lead to a more complete understanding of the full cost of each of our programs.

VA has a variety of other management improvement efforts underway that will lead to greater efficiency and will be accomplished largely through centralization of several of our major business processes. I am committed to reforming the way we conduct our information technology (IT) business, and to help the Department meet this objective, we have aggressively pursued new approaches to accomplishing our IT goals. We have developed a One-VA enterprise strategy, embarked on a nationwide telecommunications modernization program, and laid a solid foundation for a Departmental cyber security program. In order to facilitate and enhance these efforts, I recently centralized the IT program, including authority, personnel, and funding, in the office of the Chief Information Officer. This realignment will serve to strengthen the IT program overall and ensure that our efforts remain focused on building the infrastructure needed to better serve our Nation's veterans.

This budget includes $10.1 million to continue the development of the One VA Enterprise Architecture and to integrate this effort into key Departmental processes such as capital planning, budgeting, and project management oversight. Our request also includes $26.5 million for cyber security initiatives to protect our IT assets nationwide. These initiatives aim to establish and maintain a secure Department-wide IT framework upon which VA business processes can reliably deliver high-quality services to veterans.

The 2004 budget includes funds to continue the CoreFLS project to replace VA's existing core financial management and logistics systems—and many of the legacy systems interfacing with them—with an integrated, commercial off-the-shelf package. CoreFLS will help VA address and correct management and financial weaknesses in the areas of effective integration of financial transactions from VA systems, necessary financial support for credit reform initiatives, and improved automated analytical and reconciliation tools. Testing of CoreFLS is underway, with full implementation scheduled for 2006.

We are developing a realignment proposal for finance, acquisition, and capital asset functions in the Department. A major aspect of this effort centers on instituting much clearer delegations of authority and improved lines of accountability. This plan would establish a business office concept across the Department and would enhance corporate discipline that will lead to uniformity in operations and greater accountability, and will make the transition to the new financial and logistics system much easier to implement. A component of the plan under review and consideration will result in a consolidated business approach for all finance, acquisition, and capital asset management activities.

Mr. Chairman, I am proud of our achievements during the last year. However, we still have a great deal of work to do in order to accomplish the goals I established nearly 2 years ago. I feel very confident that the President's 2004 budget request for VA will position us to reach our goals and to continue to provide timely, high-quality benefits and services to those who have served this Nation with honor.

That concludes my formal remarks. My staff and I would be pleased to answer any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. ARLEN SPECTER TO HON. ANTHONY PRINCIPI

Question 1: The proposed budget shows collections of $1.172 billion in fiscal year 2002 and then estimates that this amount will increase to $2.141 billion in fiscal year 2004. To what does VA attribute this increase in projected collections?

Answer: The increase in estimated collections for FY 2004 is primarily attributable to planned legislative changes that will improve VA's ability to increase collections. First, increases in first-party co-payment amounts charged to veterans should result in improved collections for FY 2004. Second, legislation that will require managed-care companies to remit payment for both urgent and emergent care will result in significantly increased collection amounts. Third, legislation to require veterans to disclose health insurance coverage information will improve collections for FY 2004. Section 112 of Title I of Division K of Public Law 108-7, signed February 20, 2003, now limits the use of appropriated funds for medical treatment of certain non-service connected veterans who do not provide accurate insurance information.

In addition to legislative changes, VA believes improved collections will come from a variety of program changes including automation of claims processing through electronic interfaces for insurance verification, insurance identification, billing, and third party check processing. VA continues to work on improving the automation of

information between registration and claims development. Finally, VA is pursuing completion of its Patient Financial Services demonstration project that will facilitate the implementation of a commercial off-the-shelf solution to claims processing issues.

VA does recognize, however, that the FY 2004 collection goal of $2.141 will be a challenge, particularly in light of recent changes restricting enrollment of new Priority 8 veterans. VA estimates a potential loss of revenue of $36 million per year from first and third-party collections previously projected for these veterans.

Question 2: The proposed budget requests, despite an aging veteran population, a decrease of almost $200 million in expenditures devoted to nursing home care—from a fiscal year 2003 level of $2.054 billion down to $1.855 billion in fiscal year 2004. How does VA plan to provide nursing home care for increasing numbers of older veterans with less money?

Answer: Under 38 U.S.C. 1710A, VA is required to provide nursing home care to any veteran who needs such care for a service-connected disability or to any veteran who needs nursing home care and has a service-connected disability rated 70 percent or more. Provision of nursing home care to all other veterans is discretionary. VA plans to provide nursing home care to all veterans mandated under the Millennium Act when they are in need of nursing home care and choose to receive it from VA. In addition, VA plans to provide needed nursing home care to veterans who are in the discretionary group, with priority given to those in need of post-hospital rehabilitation or special care, hospice care, respite care, intensive geriatric evaluation and management, and care for spinal cord injury or disease. In accordance with the recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care, VA will also continue to support a rising number of veterans in State Home nursing homes. Increasingly, however, VA anticipates providing needed care for elderly veterans in less restrictive, less costly home- and community-based non-institutional settings.

Question 3: The proposed budget suggests that Priority 7 and 8 veterans be charged a $250 annual enrollment fee. As you know, I strongly supported the creation of so-called new Priority 7 veterans by advancing legislation to assist veterans residing in high cost areas of the country (such as Philadelphia) who do not qualify for Priority 5 status despite their relative poverty due to residence in high cost areas. With that in mind, why do you propose to charge these Priority 7 veterans the same $250 enrollment fee that you would charge Priority 8 veterans? Given the intent of Congress to create a new category of low income veterans who would qualify for preferential treatment, shouldn't these veterans, for purposes of a proposed annual enrollment fee, be treated like Priority 5—not Priority 8—veterans?

Answer: The proposed policies were designed to ensure that VA is able to refocus its health care system by providing timely access to high-quality health care to currently enrolled veterans, and in particular to our "core" veterans, those with service-connected disabilities, low incomes, and special needs. The cost-sharing proposals would only affect higher-income, better-insured veterans in the lowest priorities and have been strategically priced to help refocus the VA health care system as stated above.

According to data from the 2002 VHA Survey of Veteran Enrollees, 90 percent of Priority 8 enrollees and 87 percent of Priority 7 enrollees have some type of public or private health care coverage (compared to just 70 percent for Priority 5 and 73 percent for Priority 1 enrollees). These policies discourage use of VA by veterans who, for the most part, do not use VA as their primary provider of care but supplement their other care options with services from VA when it is financially opportune for them. Under the proposed policies, these veterans who choose to use VA selectively, such as those who come to us only for prescriptions, can make the economic decision to continue to do so. Most importantly, those veterans who do not have other health care options can still access the high quality, comprehensive care VA provides at a very minimal cost.

Priority 7 veterans currently receive preferential treatment in terms of a reduced inpatient co-payment requirement and an enrollment priority assignment above that of other higher-income veterans. Moreover, the proposal would exempt Priority 7 veterans with service-connected disabilities rated at zero percent from the requirement of paying the annual enrollment fee. Priority 7 veterans continue to be responsible for full outpatient and medication co-payment requirements. Therefore, application of the enrollment fee to the non-service-connected Priority 7 veterans would be consistent with our policy of asking them to pay a higher portion of the cost of their care than do those veterans who comprise our core constituents.

Question 4: One of the policy proposals in your proposed budget envisions Congress enacting legislation deeming VA to be a preferred provider for PPO-type private health insurance plans and HMO's. Would this proposal require veterans to de-

clare VA to be their sole health care provider? Would such a program require veterans to forfeit rights under their PPO or HMO plans?

Answer: The proposal would not require veterans to declare VA to be their sole health care provider. Nevertheless, it is possible that this could occur in cases where a PPO or HMO requires each member to designate a plan/network provider as his or her sole health care provider.

Our proposal, of course, does not, and is not intended to require veterans to forfeit any rights under their HMO or PPO plan. Moreover, we believe it unlikely that those plans, due to enactment of this legislation, would discriminate against veterans by imposing such forfeiture. Were they to do so, we believe such action would be constitutionally suspect.

Question 5: Your proposed budget estimates a reduction in nursing home care staff of 887 in fiscal year 2004—presumably due to your proposed elimination of VA authority to provide nursing home care to veteran that are not at least 70 percent service-connected or those needing post-acute care.

Question 5A: Does VA maintain that it currently has the authority to carry out this policy change without new statutory language being enacted into law?

Answer: Under 38 U.S.C. 1710A, VA is required to provide nursing home care to any veteran who needs such care for a service-connected disability or to any veteran who needs nursing home care and has a service-connected disability rated 70 percent or more. Provision of nursing home care to all other veterans is discretionary under a proposal to amend a VA regulation, however, priority will be given to veterans in the discretionary group who are in need of post-hospital rehabilitation or special care, hospice care, respite care, intensive geriatric evaluation and management, and care for spinal cord injury/disease.

VA understands that a change to the Millennium Act is required in order to reduce the level of effort and staffing in VA nursing homes below the 1998 baseline level. VA is proposing that VA's three nursing home care programs (VA operated, contract community and State home), VA and State domiciliary, and VA and contract home and community-based care in total be utilized as the 1998 baseline.

Question 5B: What is the rationale for proposing to limit VA's authority to provide nursing home care to this narrowly defined group of service-connected patients?

Answer: The rationale for this approach is two fold. First, it is part of a general VHA initiative to refocus on our primary mission to care for veterans with service-connected disabilities, low incomes, and those with special needs. Secondly, it optimizes use of VA nursing home care beds, which are staffed to provide rehabilitative and other special services for the priority groups designated above.

Question 5C: Is there a reason VA's proposal would bar nursing home care to service-connected veterans in need of such care for their service-connected condition? Does VA anticipate requiring those veterans to obtain care from the State Home system or private sector with VA as a buyer or services?

Answer: VA's proposal continues to include service-connected veterans in need of nursing home care for their service-connected disabilities in the mandatory group, as required by 38 U.S.C. 1710A. VA will provide that care in VA nursing homes, contract community nursing homes, or State veterans homes, whichever is most appropriate clinically and is in keeping with the individual veteran's circumstances.

Question 5D: How much staff depletion in the area of VA nursing care do you anticipate over the next five years when many of the current patients, who would be grandfathered in under your proposal, are no longer under VA care?

Answer: VA does not anticipate depletion of staff since we plan significant expansion in home and community-based extended care, including VA Home-Based Primary Care and care-coordination services.

Question 5E: Do you envision lay-offs or reductions in force for the affected employees?

Answer: VA anticipates that affected staff will have the opportunity to be reassigned to other inpatient units or outpatient programs, including other geriatric and extended care programs.

Question 6: Presumably, VA's proposed restrictions on its authority to provide institutional care to veterans would not eliminate the current system of per diem payments to State Veterans' Homes.

Question 6A: Please explain the role you envision the State Veterans Homes' playing in the new policy proposal.

Answer: In accordance with the recommendations of the Federal Advisory Committee on the Future of VA Long-Term Care, VA envisions the State Veterans Homes playing a larger role in the provision of long-term care to veterans, particularly with the expansion of beds through the State Home Construction Grant Program. VA will continue to provide per diem payments for veterans receiving care in State homes, including those veterans who need long-term maintenance care.

Question 6B: Do you intend to discontinue current relationships with private sector facilities providing care on a contractual basis? Or will that service simply be available to 70 percent service-connected disabled veterans?

Answer: VA does not intend to discontinue relationships with community nursing homes. VA will continue to survey community nursing homes annually to establish or renew contracts with those facilities meeting VA standards of care.

Question 7: Your proposed budget notes that you expect to lose approximately 379,000 Priority 7 and 8 veterans in fiscal year 2004 as a result of the new enrollment fees and co-payment increases.

Question 7A: How many of those Priority 7 and 8 veterans will be able to access care through other methods such as Medicare, private health insurance, etc.?

Question 7B: How would you respond to the criticism that you are "pricing veterans out of the system on purpose" as a method of managing health resources?

Answer: The demand for VA health care has reached unprecedented levels, and it is clear that workload growth of the magnitude we have seen in recent years is unsustainable in the current federal budget climate. These proposed policies were designed to ensure that VA is able to fulfill its core mission—providing timely access to high quality health care to veterans with service-connected disabilities, low incomes, and those with special needs. The cost-sharing proposals would only affect the lowest priority veterans in Priority 8 and non-service-connected veterans in Priority 7, and have been strategically priced to refocus the VA system on those veterans who need us most.

According to data from the 2002 VHA Survey of Veteran Enrollees, 90 percent of Priority 8 enrollees and 87 percent of Priority 7 enrollees have some type of public or private health care coverage (compared to just 70 percent for Priority 5 and 73 percent for Priority 1 enrollees). These policies discourage use of VA by veterans who, for the most part, do not use VA as their primary provider of care but supplement their other care options with services from VA when it is financially opportune for them. Under the proposed policies, these veterans who choose to use VA selectively, such as those who come to us only for prescriptions, can make the economic decision to do so. Most importantly, those veterans who do not have other health care options can still access the high quality, comprehensive care VA provides at a very minimal cost.

Question 8: Your proposed budget assumes management savings of $1.1 billion during fiscal year 2004. What types of health delivery service changes do you expect to achieve these savings? What types of commercial activities will VA be reviewing to determine appropriateness for private sector competition?

Answer: Following are the management and administrative efficiencies anticipated for FY 2004:

Competitive sourcing. VA has begun a rigorous analysis of appropriate areas to study under its competitive sourcing plan to determine whether commercial activities should be performed in-house using Government facilities and personnel or through private sector performance-based contracts. Our goal is to ensure the best service to our customers while managing resources to determine whether the same or a higher-quality service can be provided at a lower cost. The first round of studies under competitive sourcing review are primarily Veterans Health Administration (VHA) activities to include such areas as diagnostic radiology, pharmacy, medical libraries, grounds management operations, laundry and dry cleaning operations, medical information and records, nutrition and food service, etc.

Reforms for Health Care Procurement Process. VA has the second largest number of purchases in the federal government after DoD even though it ranks sixth in procurement spending. Standardizing items that are purchased most often will leverage VA's purchasing power. VA is in the process of implementing aggressive strategies to: (1) leverage purchasing power of VA; (2) standardize equipment and supplies; and (3) obtain and improve comprehensive procurement information.

Administrative saving. VA made significant choices regarding administrative costs during the FY 2004 budget process. Administrative areas such as employee travel, interagency motor pool, IT contracts, personal service and training contracts, and other medical contracts were reduced. Other operational areas such as maintenance and repair services, operating supplies and materials are anticipated to be maintained at or below 2003 spending levels.

Employee productivity. VA is reviewing all aspects of operations, including providers, to ensure that all employees are delivering care to our veterans in the most productive manner. Particular focus is on physicians to ensure that every hour of medical expertise that VA pays for is delivered to veterans.

Local Network efficiencies. Each VISN's management is charged with actively reducing per-patient cost for healthcare. Efforts to date have resulted in good progress towards this goal, but more can and will be done. Medical centers continue to pur-

sue opportunities to provide quality care in less costly settings, carefully analyzing each new lease opportunity as it arises. Efforts to shift excess acute inpatient resources, although largely accomplished, can still yield some savings. Wherever resource decisions are made locally, emphasis will be placed on receiving the best value for the investment.

Question 9: You note a desire on the part of the Administration to invest $225 million to implement specific recommendations of the CARES commission.

Question 9A: Are you asking this Congress and, more specifically, this Committee, to approve a blanket authorization that would allow the Administration to decide where and when to spend this money?

Answer: The Department has requested an appropriation of $225 million for major construction in support of the implementation of the CARES recommendations. The Secretary is planning on approving the CARES National Plan by November, 2003.

Question 9B: Assuming this committee might be willing to consider such a "blanket" authorization, how would you propose to consult with members on both sides of the aisle before undertaking such massive expenditures?

Answer: Because of the CARES timeline, VA decided that it would be more prudent to delay selecting construction projects for the FY 2004 authorization until the National Plan is approved. VA intends to review and identify construction projects and develop a five-year plan. In February 2004 VA will submit to Congress the five-year plan and request authorization for the FY 2004 appropriations and the FY 2005 appropriations. At the present time VA is requesting that Congress authorize those projects listed in VA budget submission, which include Chicago West Side construction and leases at Boston, MA, Denver, CO, and Pensacola, FL. A request for authorization of the lease at Charlotte, NC, was included in the FY 2004 budget request since at the time of publication that lease had not been authorized as a part of the FY 2003 authorization process.

Question 9C: Do you have any sense now where VA's capital infrastructure needs are the greatest?

Answer: VA will not know where our greatest infrastructure needs are until the Secretary approves the CARES National Plan. VA has previously identified critical seismic safety projects in California that are considered as Department needs.

Question 10: During last year's budget hearings I suggested that VA do a better job of collecting money from third-party sources. What improvements have you made in the past year? May I assume from your proposed budget, which States that VA will improve collections by another $155 million in fiscal year 2004, that VA still has areas in which it can improve its ability to collect money from insurance companies?

Answer: In the past year, VA has substantially improved its ability to collect money from third party sources through the initiatives outlined below.

(a) *Full automation of electronic data interchange* to allow electronic submission of claims to first party payers. Automation of claims processing results in claims being paid timely and improves cash collection. An average of 374,000 e-claims are being submitted every month, and as of January 2003, cumulative totals are nearing the three million claims mark.

(b) *Development of performance metrics* to benchmark VA against industry best practices for revenue including: collections, cost to collect, days to bill, accounts receivable greater than 90 days old, percent collected of amount billed, and total billings. VA has developed a website to track and trend metrics in these key areas. Additionally, establishment of benchmarks tied to performance contracts for senior managers has improved our ability to monitor progress in key areas.

(c) *Reduction of Accounts Receivables*—VA has developed an aggressive program to reduce outstanding accounts receivable including mandating that accounts be turned over for collection action at the 60-day mark. Aggressive follow-up of accounts in partnership with private vendors has facilitated reduction of accounts receivable. Additionally, VHA has partnered with the Financial Quality Assurance division in Austin to review all aging outstanding and residual balances.

(d) *Coding*—In FY 2002, the Deputy Under Secretary for Health for Operations and Management issued guidance for VA sites to purchase encoding software. This software enables coders to more accurately and efficiently code encounters and to measure coding productivity. As part of coding improvement efforts, VA has developed tools to improve the source documentation created by providers including documentation templates and electronic encounter forms which provide clinicians more detailed codes and information on coding requirements. Finally, many VISN's and VA Medical Centers have contracted with external vendors to provide coding services as a means to improve lag time in billing and collections.

Although VA has initiated a number of additional improvement initiatives, much remains to be done to optimize revenue cycle processes. In particular, VA is continuing to finalize the development of software to automate insurance identification and verification. VA is working closely with private industry to integrate an off the shelf software solution to improving bill production. Finally, VA is working on developing automated tools to track and trend denials by insurance carriers in order to improve front end processing. It is expected that improved insurance identification, billing, and accounts receivable management will assist us in meeting future collection goals.

Question 11: You proposed to extend into fiscal year 2004 your current policy of prohibiting enrollment for new Priority 8 veterans while still "grandfathering in" all veterans who enrolled for care prior to January 17, 2003. Do you believe that VA needs to make some allowances for those recently separating from the service since these veterans have had not opportunity to enroll at all?

Answer: The suspension of enrollment of Priority 8 veterans and the proposed policies in VA's FY 2004 budget are designed to ensure that VA can provide timely access to high-quality care for currently enrolled veterans. Veterans who separate from service after January 17, 2003, and have a compensable service-connected disability, have low incomes, or special health care needs are eligible to enroll in Priorities 1 through 7. In addition, recently discharged veterans who served in combat locations can receive health care for conditions potentially related to their service for two years after their release from service.

Question 12: Your proposed budget requests an increase of nearly $10 million for the National Program Administration (formerly "MAMOE") account to support a reorganization of the Office of the Under Secretary for Health and include a new position of Deputy Under Secretary for Health Policy.

Question 12A: Please explain to the Committee how this reorganization will comply with the organization mandated by 38 U.S.C. §7306.

Question 12B: Does VA intend to submit legislation proposing the elimination of the current Deputy Under Secretary or simply renaming the current position to reflect the Health Policy responsibilities?

Answer: Section 7306 of Title 38 U.S.C. defines and authorizes the organizational structure for the Office of the Under Secretary for Health. This section mandates that there shall be a position of Deputy Under Secretary for Health, who shall be the principal assistant of the Under Secretary for Health, and who shall be a qualified doctor of medicine. Title 38 further establishes a specific, unique rate of pay for this position, together with a unique amount of "Responsibility Pay" under the Special Pay provisions outlined in Section 7433.

Section 7306 (a) (4) further authorizes the appointment of such Medical Directors as may be necessary to suit the needs of the Department. The position of Deputy Under Secretary for Health Policy has been established as one of these Medical Directors. Both the base rate of pay and the responsibility pay component of the individual's Special Pay are lower than those designated for the statutorily mandated position of Deputy Under Secretary for Health.

In summary, section 7306 mandates the establishment of the Deputy Under Secretary of Health position with rates of basic pay and responsibility pay that exceed those of any other position established under the provisions of the section.

Conversely, however, section 7306 does not preclude the Department from assigning the "Deputy Under Secretary for Health" title to other positions that may be properly established under other provisions of section 7306 or Title 5. VA believes the "Deputy Under Secretary for Health" title should be reserved for a very small number of senior staff, and currently has established only two such positions, Deputy Under Secretary for Health for Operations and Management, and Deputy Under for Health for Health Policy. VA has no plans to establish any additional such positions at present.

Accordingly, the Department does not intend to submit requests to either eliminate or rename the statutory Deputy Under Secretary for Health position, as the current language in section 7306 provides sufficient flexibility to meet its organizational needs.

Question 13: One of your performance goals includes ensuring that 90 percent of VA medical centers have electronic access to DoD health information for separated service members. One year ago, no VA medical centers had such access. What gives VA the confidence to attempt such a large achievement in such a short amount of time? What are the positive effects such access would have on the care of newly separated servicemen and women?

Answer: The Federal Health Information Exchange (FHIE) program, a successor to the Government Computer-based Patient Record (GCPR) project, uses the VA Computerized Patient Record System (CPRS) as a fundamental building block.

CPRS has been in use at VA medical facilities nationwide, and enables an authorized user to access clinical data from any VA health facility.

The FHIE repository is a database that receives available DoD electronic clinical data. Presently, the DoD data available from their Composite Health Care System (CHCS) I systems are radiology reports, laboratory results, outpatient prescription data, cytology reports (including gynecology data), inpatient episode information, patient demographics, and inpatient discharge summaries, when available electronically. Currently, CPRS is the application that enables VA to import and display DoD clinical data from the FHIE repository, in addition to displaying clinical data available within VA.

In December 2000, a joint, interagency team was formed to deliver a system that would provide the one-way transfer of clinically relevant Department of Defense (DoD) electronic health information for use by authorized VA staff.

On April 26, 2002, a review of the FHIE test results occurred to determine whether or not the first phase of FHIE is ready for deployment. Based on the results of this review, it was determined that FHIE was ready and was deployed on Memorial Day, 2002. The first phase of FHIE was completed July 17, 2002.

On May 3, 2002, the Deputy Secretary, Department of Veterans Affairs, and the Under Secretary (Personnel and Readiness), Department of Defense signed a Memorandum of Agreement (MOA) for the Federal Health Information Exchange Governance and Management. This MOA designates VA as the lead agency for FHIE and commits executive level support necessary to adequately manage the project.

VA has confidence in this work, as the software components built for FHIE have been reused from specific VA software already in use by VA staff. These software components were able to be leveraged and gave a foundation for development of the FHIE software within Veterans Health Information Systems and Technology Architecture (VistA). Through reuse of both existing DoD and VA software, rapid development of a jointly developed, working system is possible.

Today, 100 percent of all VA Medical Centers have implemented CPRS remote data views, which enable access to DoD health information. The FHIE system has clinical data on over 1.5 million separated service members and is operating around-the-clock at a secure VA data center. During FY 2004, this joint VA/DoD project will achieve all approved requirements. Late in FY 2004, this system will attain a "steady state" and be maintained throughout its project lifecycle.

The FHIE repository is presently receiving about 20,000 newly separated health records monthly. FHIE has a number of positive effects for newly separated servicemen and women:

(1) With DoD electronic health data now available, VA clinicians have immediate access to accurate, specific historical health information from treatment received at Military Treatment Facilities, where those data were entered electronically into the CHCS, before discharge from the military.

(2) Satisfaction with care can be enhanced when veterans know their DoD and VA clinical data is linked in a longitudinal fashion using the existing technology of VA's Computerized Patient Record System (CPRS). This new jointly developed system seeks to enhance veterans' confidence in the ability of VA to assess and understand their health conditions using electronic health information obtained from their military service.

(3) VA staff helping newly separated veterans seeking benefits from VA has historical electronic DoD health data readily available to them during compensation and pension examinations.

(4) In July 2003, the Veterans Benefits Administration (VBA) will begin using a new release of VA developed software called Compensation and Pension Record Interchange (CAPRI). This update of existing software will permit authorized VBA users to access DoD clinical data stored in the FHIE repository to assist in their delivery of service.

Question 14: Your proposed budget briefly outlines a program under which you would work with the Centers for Medicare/Medicaid Services (CMS) to obtain information that would allow VA to work with Medigap insurers. Will this information allow veterans to be reimbursed for co-payments and other VA financial obligations if they are covered by a Medigap policy?

Answer: The VA-CMS project mentioned is the electronic Medicare Remittance Advice (e-MRA) Project, a joint effort between VA and CMS to solve a long-standing problem that Medigap insurers have had with VA. Because VA does not bill Medicare directly, Medigap insurers have had difficulty trying to determine payments due VA. The goal of this project is to acquire a Medicare equivalent explanation of benefits from Medicare outlining the deductible and coinsurance amounts. This information will be shared with Medigap insurers so that they better understand their financial obligation to VA. One of the provisions of Medigap insurers includes cov-

erage of the Medicare deductible and coinsurance amounts to which VA may be entitled. The dollars recovered from these third-party insurers currently help to offset veterans' co-payments and financial obligations. However, there are instances where these payments do not fully cover VA co-payments, and veterans are still obligated to VA for the balance of the co-payments.

Question 15: VA has identified many different Capital Investment Activities as part of the overall Medical Care Business Line, including major and minor construction, State home grants, asbestos abatement, etc. Do you believe that it would benefit VA to devise a program or process for destroying and removing old and dilapidated structures that currently plague many VA medical facility campuses?

Answer: As a part of the VA CARES process, facilities are identifying excess property and will be developing exit strategies for the use of those structures after the Secretary approves the plans. Those exit strategies may include sharing or leasing the space, enhanced use, use by other government agencies, demolition, or mothballing. Funding to implement the selected exit strategy will come from the appropriate funding category.

Question 16: Your proposed CARES Construction budget requests $183 million for fiscal year 2004. According to the budget documents, $98.5 million will be allocated for work associated with the Chicago West Side facility's modernization program. Please provide the committee with a more detailed description of this proposal.

Answer: Construction includes a new multi-story bed tower to house 200 inpatient beds for our VA Medical Centers at Chicago Westside and Chicago Lakeside Divisions. The project will also provide for a new surgical suite and will be connected to the West end of the existing hospital where ancillary support and diagnostic functions will remain. Building 1 will provide for consolidated renovated inpatient support services.

Question 17: You propose that current law be amended to allow VA to count all institutional and non-institutional long-term care services to meet the capacity requirements set forth in 38 U.S.C. 1710B. What do you propose as a baseline for this change in policy? Do you believe that current institutional services provided at State homes and contract nursing facilities must be taken into account when determining a baseline?

Answer: VA would retain 1998 as the baseline year and specify the baseline level of effort at 54,585 ADC for all institutional and non-institutional services combined. VA has included the institutional services provided veterans at State homes and contract nursing facilities at VA expense in its proposal to amend 38 U.S.C. § 1710B.

Question 18: Your continued support for increased funding of the State Home Construction grant program ($102 million in fiscal year 2004) suggests that the Administration acknowledges the value of States as partners with the Federal government in providing long-term care to veterans.

Question 18A: How does the proposal to count all institutional and non-institutional long-term care services in the capacity requirement co-exist with a continued expansion of the State home construction program?

Answer: VA highly values its long-standing partnership with the States in the provision of long-term care to veterans in State homes. VA envisions the State homes playing a larger role in the provision of long-term care for veterans in the future. Continued expansion of the State home construction program will permit that to occur and will help VA to meet the capacity requirement if the proposal to count all institutional and non-institutional long-term care is enacted.

Question 18B: Does VA propose to readjust baseline assumptions for areas that construct new State homes in the future?

Answer: Since the capacity requirement will be met on a national basis, readjustment of the baseline on a local basis will not be necessary. VA will, however, attempt to assure equity of access to a range of institutional and non-institutional long-term care services throughout the VA system. State home construction project proposals are already required to demonstrate that there is a local need for additional bed capacity for long-term care of veterans in order to be eligible to receive Federal construction grant funding.

Question 19: In testimony given on January 29, 2003, before the House Veterans Affairs Committee, VA's Under Secretary for Health noted VA's compensation system for physicians and dentists is unresponsive to the demands of the current market. The effect of noncompetitive pay and benefits is seen in dramatic increases in VA's scarce-specialty, fee-basis, and contractual expenditures." Despite this statement, VA's proposed budget proposes nothing to alleviate the concern expressed by the Under Secretary.

Question 19A: What would it cost for VA to implement a program under which VA could compete for qualified physicians and other clinicians to work as VA employees rather than contractors?

Answer: The amounts of special pay authorized for physicians have not been adjusted since 1991 and are no longer competitive for many specialties and categories of physicians. After 1991, physician staffing stabilized or improved in most medical categories for a time. However, VA's current competitive situation is eroding in many areas of the country and will continue to erode due to the current limits on special pay amounts. Increased enrollment by veterans for VA health services and the need for more comprehensive care by aging veteran patients will result in increased workloads across the system over the next 5 years. Current trends indicate a steady decrease in the number of physicians VHA will employ over the same period. This decrease will be the result of increased retirements (currently, 25 percent of VA physicians and 50 percent of VA dentist retirement eligible), losses to the private sector, and increasing difficulty in recruiting replacements. This is already being evidenced by increasing vacancy rates, increasing times to fill medical specialist positions, and by the growth of scare medical specialist contracts, which increased from $643 million in FY 1995 to $2.16 billion in FY 2001, a 336 percent increase in this six-year period. VA has estimated that it would cost approximately $2.12 billion over the next 10 years to effectively compete for qualified physicians and dentist rather than contractors.

Question 19B: When can the Committee expect proposals from the Administration to address this problem?

Answer: VA is currently working on a legislative proposal that is under final review across the administration.

Question 19C: What is your management philosophy for addressing this issue? Will you allow one-time bonuses? Locally-varying pay scales? Removal of salary caps?

Answer: VA favors a pay system with the following components: a uniform base pay band for all positions; market sensitive pay set by specialty, assignment, location, and experience; and performance-based bonuses for meeting quality and productivity measures, or for supporting corporate goals.

Question 20: Some members of Congress and Voss's have advocated a type of guaranteed funding for VA health care. Other members expressed concerns about the wisdom of such a policy and fear unintended consequences of such a change in the funding mechanism. Provide the Committee with the Administration's views on such proposals—specifically S. 50 introduced by Senator Tim Johnson—including reasons for supporting or opposing this change in budget processing. What are VA's views on H.R. 5250, the Veterans Health Care Funding Guarantee Act of 2002, introduced in the last Congress?

Answer: VA's views were not sought on this 10th Congress bill, hence no formal position was developed. We have developed views on a similar bill, S. 50 with Congress, at the request of Senator Johnson. This legislation would establish, by formula, the annual level of funding for all programs, activities, and functions (except for grants to States for the construction or acquisition of State homes for veterans) of the Veterans Health Administration (VHA). More specifically, funding for FY 2005 (the first fiscal year covered by the bill) would be automatically established at 120 percent of the amounts obligated by VHA (for all its activities, programs, and functions) for FY 2003. Thereafter, VHA funding would be automatically determined by a fixed formula, which is based on the number of enrollees each year multiplied by a fixed per capita amount. The per capita amount would be adjusted annually in accordance with increases in the Consumer Price Index.

VA does not support the concept of using a fixed formula to determine VHA funding. Although VA recognizes the appeal of such an approach, particularly in these times when the Department finds it is unable to provide care to all veterans who seek enrollment in the system, we believe the approach taken in this and other similar bills would prove to be unworkable and is inappropriate for funding a dynamic health care system, like VA's.

The provision of care evolves continually to reflect advances in state of the art technologies (including pharmaceuticals) and medical practices. It is very difficult to estimate both the costs and savings that may result from such changes. Moreover, patients' health status, demographics, and usage rates are each subject to distinct trends that are difficult to predict. The proposed formula in S. 50 would not take into account any changes in these and other important trends. As such, there is no certainty that the amount of funding dictated by the proposed formula would be adequate to meet the demands that will be placed on VA's health care system in the upcoming years.

Perhaps more importantly, use of an automatic funding mechanism would also diminish the valuable opportunity that members of the Congress and the Executive Branch now have to carry out their responsibility to identify and directly address the health care needs of veterans through the funding process. It might also tend

to depress the Department's incentive to improve its operations and be more efficient.

Finally, VA does not believe this proposal would ensure open enrollment. The Department would still be required to make an annual enrollment decision, and that decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula. Indeed, references to "guaranteed funding" may give the public the false impression that this bill would give VA full funding to enroll all veterans and to furnish care for all their needs, which would not be the case.

We share the desire by many in Congress to ensure stable funding for the Department's health care system, and we look forward to working closely with the Congress to achieve that goal. However, for the many important reasons discussed, we believe the approach taken in S. 50 is not the answer.

Question 21: In recent months, the President has activated much Guard and Reserve troops to fight in the war against terrorism and participate in the "build-up" in the Middle East. Recent testimony by AMVETS notes that VHA currently employs over 13,000 reservists. Do you anticipate a large contingent of VA employees being called up for active duty service in the near future? What are VA's plans for addressing the possible loss of a significant amount of clinical staff?

Answer: The Department of Veterans Affairs (VA) does anticipate a large contingency of VA employees being called to active duty. According to DoD's Military Mobilization List, as of December 31, 2002, there are 15,204 VA employees subject to military mobilization. Of that number, 6,253 VA employees are in health care related occupations. The Veterans Health Administration (VHA) recently completed a review of the occupations subject to becoming vacant as a result of military mobilization. Each VISN prepared a contingency plan to address staffing needs in the event significant numbers of clinical and non-clinical employees are called to active duty.

VHA's contingency plans identified the following staffing strategies to address personnel shortages in clinical positions:

- Utilize the array of OPM hiring authorities, such as: Direct hire authority, temporary or term appointments, and reemployment of Federal retirees.
- Reassign or detail existing staff.
- Offer overtime, compensatory time; and adjust work schedules.
- Make use of fee basis and contract arrangements for positions such as dentist, optometrist or primary care physicians.

Question 22: The President's budget uses a new analytical tool—the Program Assessment Rating Tool (PART)—to help evaluate the effectiveness if Federal programs. Using PART, the disability compensation program was given a rating of "results not demonstrated." The main reason given for the poor rating is that compensation for certain disabilities and diseases has little relation to veterans' reduced income-generating capacity in a 21st century economy. What is your assessment of the PART analysis of the disability compensation program?

Answer: We agree with the stated goals of the Program Assessment Tool (PART)—to evaluate Federal programs in a systematic, consistent, and transparent manner and to use the results to help inform management and budget decision-making. As a result of the PART, it became apparent that the program lacks long-term outcome goals as well as cost-efficiency measures. In 2004, VA will initiate a program evaluation. The results of which should improve the program's score.

Question 22A: Is the criticism that the compensation is not meeting its purpose valid?

Answer: We agree with the stated goals of the Program Assessment Tool (PART)—to evaluate Federal programs in a systematic, consistent, and transparent manner and to use the results to help inform management and budget decision-making. VA recognizes that the disability compensation program needs meaningful long-term outcome goals as well as cost-efficiency measures, and we have been working to address this issue. PART has further emphasized the need for improvement in this area. Therefore, in 2004, VA will initiate a program evaluation.

Question 23: Last year's budget commented on VA's failure to establish a relationship between resource expenditures and performance in the disability claims process. Is VA any closer to establishing this link? What efforts underway will better enable Congress to determine whether investments in particular initiatives have a measurable impact on claims processing performance?

Answer: We are enhancing our budget formulation and resource allocation models, as well as our budget execution process. To support this effort, we have contracted with the Institute for Defense Analyses (IDA). The budget formulation model currently forecasts performance, incoming workload and completed workload. The resource allocation model takes the resources approved by Congress and distributes

them to the field offices. The outcome of our enhancement project will be to link these two models with our budget execution process to better assess our efficiencies and performance gains. This project began in March 2003. IDA expects to have a beta version of the model available in December 2004.

Question 24: The proposed budget states that its new account structure "represents a significant step forward in our ongoing effort to more effectively link resources with results." How so? For example, how does combining mandatory disability compensation payments and discretionary administrative expenses give a clearer indication that VA is achieving the result of improving the timeliness and accuracy of claims processing?

Answer: The overarching goal of our initiative to restructure the Department's budget accounts is to better understand what results we are achieving in return for the total resources devoted to each of our nine programs—medical care; research; compensation; pension; education; housing; vocational rehabilitation and employment; insurance; and burial. The new account structure ensures that all of the costs associated with each program are grouped together rather than having them split among different programs. When all resources for a program are included within a single account, we are better positioned to understand what we are getting in return for these resources, both in terms of program outcomes (what impact the program has on improving the lives of veterans and their families) and program outputs (how well we are managing the program in terms of activities like timeliness and accuracy of service).

Question 25: The Institute of Medicine (IOM) recently released a report on the association between exposures to insecticides and solvents which were present during the Gulf War and long-term health outcomes. IOM found 12 disease conditions which, at a minimum, had limited or suggestive evidence of an association with insecticide or solvent exposure. What is your assessment of IOM's findings? What action, if any, do you plan to take and what would be the budgetary impact of that action?

Answer: On February 18, 2003, IOM released its second congressionally required review of the health effects associated with certain Gulf War environmental exposures. It included 21 positive findings on long-term health effects from exposure to pesticides and solvents that may have been used in the 1991 Gulf War theater of operations. These were primarily various cancers and serious hematological disorders (e.g., leukemia, non-Hodgkin's lymphoma, multiple myeloma, and aplastic anemia), subtle general neurological effects seen in neurobehavioral tests, and certain miscellaneous health effects (e.g., reactive airway dysfunction syndrome and allergic contact dermatitis).

Most of the pesticides and solvents addressed in the IOM report are commonly used in military and civilian life and are not unique to Gulf War service. These include such common substances as dry cleaning solvents and chemicals commonly found in gasoline, antifreeze, household cleaning products, typewriter correction fluid, food, and cosmetics. The health effects noted by the IOM are generally well known. Most of the IOM's findings are qualified by the conclusion that they are associated with "chronic" or occupational exposure to the pesticides or solvents in question, as distinguished from episodic exposure. Virtually all of the data available for review by the IOM came from studies of civilian workers who were occupationally exposed to pesticides or solvents over long periods. This combination of factors has made VA's task in reviewing the IOM report a particularly challenging and sensitive one.

As with prior IOM reports, VA established an internal working group (including representatives of the Veterans Health Administration, the Veterans Benefits Administration, and the Office of the General Counsel) to review the IOM findings. As required by law, we will publish regulations and notices, as appropriate, to announce the Department's determinations based on the IOM report. We do not currently have cost estimates associated with such action.

Question 26: The proposed budget assumes Congress will enact legislation to raise co-payment fees, charge annual enrollment fees, and limit nursing home access for certain veterans—but it does not assume increased health care and compensation claims-processing costs associated with a potential war with Iraq. Has VA made any projections or assumptions relating to potential war-related costs?

Answer: VHA has made no projections or assumptions relating to potential costs of a war with Iraq in its FY 2004 budget request. Likewise, VBA's workload and performance projections do not address the potential effects of war with Iraq.

Question 27: What impact has the President's call to active duty of VA employees in the Reserves or National Guard had on VA operations?

Answer: As of March 18, 2003, 730 VA employees were mobilized. VA has identified a number of critical occupations encumbered by reservists subject to mobiliza-

tion. The number of VA employees activated in these critical occupations is monitored on a daily basis. To date, a modest percentage of our critical occupations have been affected; however, should mobilization of reservists occur more rapidly, the impact on our critical occupations could be significant.

Question 28: In order to reduce the claims processing backlog, one of the main recommendations of the C&P Claims Processing Taskforce was to free up direct labor hours so that more time could be spent processing claims. If VBA had unlimited authority to contract for C&P medical examinations, wouldn't that free up direct labor hours at VHA thus enabling it to work on reducing its own backlog of patients waiting for care?

Answer: Adoption of the recommendation of the C&P Claims Processing Taskforce most likely would not have much impact on VHA's on-going efforts to reduce waiting lists. C&P exams comprise less than 1 percent of VHA's outpatient workload on a National level. In addition, the use of contractors in all areas was not considered to be the most effective option, due to the time that would be required for contractors to scale up to the production levels necessary to meet national standards for timeliness and quality. Moreover, availability of suitable contractors in some areas could also limit the ultimate effectiveness of contracting as a tool to reduce the waiting lists.

Question 29: VA has made tough decisions regarding health care enrollments, and it has proposed fees to be imposed on Priority 7 and 8 veterans. Since a 10 percent disability rating would permit veterans who currently fall in either Priority 7 or 8 to avoid these changes, do you anticipate an increase in compensation claims by such veterans?

Answer: We assume that a certain percent of veterans rated service-connected at the zero percent level will apply for increased evaluations to change their priority status and avoid additional fees. However, a formal estimate of the number of claims expected by these changes has not yet been finalized pending results of data requests and inquiries. We anticipate having the cost estimate completed by late June, 2003.

Question 30: VBA is conducting a preliminary assessment of the impact of the Combat-Related Special Compensation Pay (limited concurrent receipt) for certain retired veterans. However, DoD is required to promulgate the rules. Has DoD involved VA in the implementation process? If, after DoD has made its decision on whether an injury is combat-related or not, the veteran disagrees with DoD's determination, to whom will the veteran be able to appeal? Will VA be required to adjudicate such an appeal? If yes, what impact, if any, do you feel such appeals will have on clams processing timeliness?

Answer: VA has been present at three DoD-sponsored meetings at the Pentagon on this issue. DoD representatives have also come to VA on five occasions to obtain a better understanding of the compensation process. In addition there has been weekly contact on the topic. Our role has been advisory and consultative. We also made observations and recommendations to DoD about the nature of the data that we have in electronic and paper form. We have suggested items to be included in their application. To the extent that DoD has asked our advice we have provided it.

DoD has indicated to us that retirees would have the normal appeal rights available to members and retirees inside the DoD system. Because VA will not be making decisions as to basic eligibility to this benefit, VA's appeals system is not available for claimants dissatisfied with DoD's decisions.

Question 31: The proposed budget projects an overall C&P workload decline in fiscal year 2004. Has VA projected workload beyond 2004? If so, what are the projections and how will they affect VA's assessment of the optimal size of VBA's workforce?

Answer: In the development of the 2004 budget submission, we did project workload beyond 2004. The table below shows the overall expected C&P workload from 2003 through 2008 at the time of the submission.

FY	2003	2004	2005	2006	2007	2008
Claims Workload	2,027,990	1,849,893	1,778,876	1,761,502	1,744,572	1,728,003

Original and reopened disability compensation claims have been declining. We experienced an increase in 2002 and 2003 because of passage of the Veterans Claims Assistance Act and the presumption of service connection for type II diabetes for veterans who served in Vietnam. However, we believe we have received the bulk

of this workload. Over the long term as the number of active military personnel decreased, we have experienced a similar decrease in the number of disability compensation claims received.

Although workload is projected to decline and VBA has been successful in improving productivity, we have not yet fully accomplished our goal of fixing the system of benefits delivery. In determining our workforce needs, we must restore the infrastructure needed to institutionalize the changes we are making as a result of the recommendations of the VA Claims Processing Task Force. Additionally, we are not yet at the level of quality we must achieve, nor have we established the training infrastructure essential to maintaining the ongoing capability of our entire workforce. All of these requirements affect the "optimal" size of our workforce and are critical to ensuring our ability to respond to workload fluctuations inherent in our system.

Question 32: You established a goal of processing disability claims in, on average, 100 days by September of 2003. Since the fiscal year 2003 funding level for VBA fell short of what the Administration requested, will VBA's ability to achieve your processing goals be compromised? If so, when will the goal be reached?

Answer: Because of our commitment to meeting the Secretary's goals for improving the timeliness of disability claims processing, VBA elected to absorb the across-the-board cut in discretionary spending primarily in our non-payroll accounts so that we could fully fund the compensation and pension payroll needs. The Under Secretary for Benefits has established specific performance targets for regional offices that are in line with the national goal of processing disability compensation claims in 100 days, on average, by September of 2003. Although much progress has been made, achievement of this goal by September 2003 remains our biggest challenge. We believe that the key to achievement of our goals involves not only sustained efforts to align our resources to ensure that we have sufficient staffing to meet the challenge, but to also carefully assess our business processes and analyze cycle times, particularly in those offices that are not currently meeting their improvement goals.

Question 33: The Independent Budget cites the lack of claims adjudicators' training in the law as a root cause of VBA's claims backlog and low accuracy rates. Has VBA analyzed accuracy rates and the productivity of employees who have law degrees? Are lawyers better suited for claims adjudication than non-lawyers?

Answer: VA has not compared the accuracy/productivity of veteran service center representatives (rating or non-rating) who have law degrees with those who do not. Over the past several years we have made an effort to recruit individuals who have specialized knowledge either in law or medicine in light of the expertise and training opportunities their knowledge provides. However, at the same time we know that a formal legal or medical background is certainly not a prerequisite for success, since many of our most experienced and best qualified personnel do not have either background.

Question 34: Congress significantly increased VBA's budget over the past four years to fund VBA's succession plan. In anticipation of a wave of retirements, the plan called for a four-year increase in full time equivalent employees (FTEE), followed by a natural reduction in FTEE through attrition. Where are we in relation to the succession plan laid out four years ago by former Under Secretary Joe Thompson? At what point will we see FTEE reductions? What is the optimal level of FTEE given VBA's expected C&P workload which, as I understand it, is projected to decline in 2004?

Answer: VBA developed a succession plan that resulted in a series of hiring initiatives over the past few years. In addition, VBA received funding to add additional FTE to support the increased workloads resulting from the Veterans Claims Assistance Act. Since 1999, VBA has added approximately 2,100 employees in the Compensation and Pension business line.

As these new employees gained proficiency in their duties, performance has improved. Over the past year with the implementation of the Claims Processing Improvement Model and other recommendations of the Secretary's Claims Processing Task Force, even greater improvements have been realized. VBA's rating inventory has decreased by 120,000 claims since its peak. Nearly 800,000 claims were processed in fiscal year 2002. Production targets are even more ambitious for fiscal year 2003.

As indicated in response to Question 31, even when we achieve our goals of 250,000 pending disability claims and 100 days on average to process these claims, our goal of fixing the system of benefits delivery will not yet be fully achieved. VBA must also devote critical resources to important long-term quality improvement initiatives, such as an ongoing standardized training program. Such initiatives will im-

pact the size of our future workforce, but are essential to maintaining the capability of our workforce and achieving consistent high quality service delivery.

Question 35: The current estimate for fiscal year 2003 spending on the C&P medical exam pilot program is 37 percent higher than what was spent in fiscal year 2002. What accounts for this spike in program expenditures? Is the program being utilized more now than in prior years? If it is being used more, what is the reason that quality of exams performed at VA hospitals and clinics has deteriorated?

Answer: During fiscal year 2002, the number of C&P examinations increased for both the VHA medical centers/clinics and the C&P contract medical examination pilot. The overall increase was due to the increased workloads and production of our field offices. As regional offices worked to meet production goals, many more contract examination requests were generated by the ten regional offices participating in the pilot program. This increase is not a reflection on the quality of examinations performed by the Veterans Health Administration. The contractor experienced a 40 percent increase in examinations during fiscal year 2002, and that volume is expected to remain high as VBA continues to reduce its inventory of pending claims.

Question 36: How many companies provide contract medical exams for VA? Is there adequate competition for this work? It is my understanding that contract medical exams are used by other federal agencies, e.g., the Social Security Administration. How does the cost of a VA compensation exam compare to costs other agencies pay for similar exams? If the costs are different, to what do you attribute the difference?

Answer: Utilizing a competitive procurement process, one company was awarded the contract for the C&P medical examination pilot. If legislation eventually expands VA's authority to contract beyond the ten regional offices involved in the pilot, our strategy would likely involve more than one contractor and also include VHA as a potential bidder. We are aware that other federal agencies utilize contractors to fulfill their examination needs. However, we are unaware of the prices for these examinations. VA's current contractor, also under contract with the Department of Labor and the Social Security Administration, has commented that VA's examination requirements are more stringent due to VA's examination worksheets that incorporate the requirements of the VA Rating Schedule of Disabilities. We believe that our examinations require a contractor to spend more time in preparing for the examination and more time during the quality review stage to ensure that all examination requirements are met.

Question 37: The proposed budget includes a $3.8 million funding request for C&P Evaluation Redesign (CAPER), an initiative intended to affect "a more consistent exam request process." The budget cites the inadequate exam return rate as evidence for CAPER's need. What is the rate at which inadequate C&P exams are returned? What is the return rate of exams performed by contractors relative to those performed by VA hospitals or clinics?

Answer: The purpose of CAPER is to improve the examination request process as well as the examination report process. The reported insufficient rates for VHA exams (AMIS 290) and for those performed by a contractor (VERIS) indicate that regional offices return 1 percent of the examination reports as inadequate for rating purposes. However, independent assessments of examinations conducted by a panel of subject matter experts from the C&P Service and the CPEP office in Nashville show that material deficiencies in both exam requests and exam reports are higher than reported. As part of the Department's efforts to dramatically reduce the claims backlog, we have encouraged cooperative relationships between regional offices and the corresponding medical centers that conduct examinations. Through these cooperative relationships, regional offices have established procedures by which they contact VA medical examiners directly by telephone to clarify examination findings and/or to request addenda to examination reports without recording the initial examination report as inadequate for rating purposes.

Question 38: Funding for CAPER began in fiscal year 2002 and was continued into fiscal year 2003. Already $4.2 million has been appropriated; your request for fiscal year 2004 would bring the total to $8 million. What is involved in the "analysis and development" of the exam request process that requires $8 million over a three-year period? When will the impact of this initiative be seen?

Answer: To date VA has requested a total of $8 million for CAPER, including the FY 2004 request of $3.8 million. By the end of fiscal year 2003 we will have expended $4.2 million: $1.4 million for payroll costs and $2.8 for development costs. Development costs include contracts with private business consultants, a software integrator, an independent verification and validation contractor, ADP equipment and software, and employee travel and training.

The purpose of CAPER is to develop a web-enabled, rules-based system for requesting C&P examinations and for producing examination reports that are consist-

ently sufficient for rating purposes, whether the source is a VA medical facility or a private contractor. The CAPER process will be consistent with the One-VA Enterprise Architecture Implementation Plan in its integration of VBA's process with VHA architecture.

CAPER is a two-phase project. Phase I, which began in July 2001, focused on a "proof of concept" prototype using commercial off-the-shelf (COTS) products. It required an analysis of our current complex business processes for requesting and receiving VA examination reports and integrating the information contained in them into a rating decision. The current process is governed by disparate manual procedures and electronic platforms resulting in inconsistent results in our field stations. The Phase I team was comprised of an integrator contractor, a multidisciplinary VA staff, and an independent verification and validation (IV&V) contractor. VA is currently assessing the prototype and analyzing alternatives with IV&V contractor assistance. The team will present its final recommendations for Phase II in the last quarter of FY 2003.

The proposal for Phase II involves a production version of the CAPER system with nationwide deployment. It will require extensive analysis to refine technical design specifications and integrate disparate VA Information Technology systems. Extensive collaboration among technical staff and business rule subject matter experts will be required.

Question 38A: When will the impact of this initiative be seen?

Answer: We anticipate initial deployment in 2006, with subsequent releases through FY 09. Improvement in the examination request process should be seen immediately in 2006, with increasing improvement as the system is fully utilized. The impact will be seen in a standardized electronic exam process that will reduce claims processing time and assure that examination reports address the necessary criteria to evaluate a veteran's disabilities. Ultimately, CAPER will increase the quality and consistency of VA rating decisions and eliminate variances based on geographic location, knowledge/experience of employees, and other factors not germane to the claim.

Question 39: What are the total estimated project costs for all current VBA initiatives for which funding is being sought incrementally? Which projects, if fully funded now and not incrementally, would have the greatest positive impact on VBA performance?

Answer: Incremental project costs for all current 2004 program-specific VBA initiatives are $32.6 million. Total costs for all initiatives, including VBA-wide Initiatives, are $53.6 million. The chart below shows VBA's initiatives. Because these initiatives must proceed in specific stages, with funding provided for each stage, and each stage built upon the results of the work preceding it, full receipt of the total funding cost for the entire initiative will not expedite the project process.

While the projects listed in the chart below each have a discreet goal, they are projects that are ongoing simultaneously and reflect a common purpose of modernizing our work processes so that we have accurate claims eligibility and other data that will enable us to provide efficient, consistent services to veterans. This goal applies across the board. "VBA-wide initiatives" affect all business lines and the specific impact on an individual business line cannot be readily identified.

Impact of Initiatives on Performance

[dollars in thousands]

	TPSS	Data Centric Architecture (VETSNET)	CAPER	Benefit Payment Replacement System	TEES	Program Specific Initiatives Cost	VBA Wide Initiative Cost	Total Initiative Cost
Initiative Cost	$2,601	$9,622	$3,821	$9,200	$7,390	$32,634	$21,021	$53,655

Question 40: The proposed budget suggests that Congress eliminate compensation benefits for alcohol and drug abuse-related disabilities which are secondary to other diagnoses, or which demonstrate the severity of a primary service-connected disability such as Post Traumatic Stress Disorder. What is VA's rationale for this proposal?

Answer: Sections 1110 and 1131 of title 38, United States Code, authorize the payment of compensation for disability resulting from injury or disease incurred or aggravated in line of duty in active service, "but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs." Before their amendment in 1990, the provisions currently codified in sections 1110 and 1131 prohibited compensation "if the disability is the result of the

veteran's own willful misconduct." In 1990 these provisions were amended to also prohibit compensation if the disability is a result of the veteran's own alcohol or drug abuse. VA implemented this statutory provision in 38 C.F.R. 3.301 (c) (2), (3) and 38 CFR 3.301 (d), providing that drug and alcohol abuse are considered for VA purposes to be willful misconduct.

In February 2001, the Court of Appeals for the Federal Circuit in *Allen* v. *Principi*, 237 F.3d 1368, 1370 (Fed. Cir. 2001) interpreted the statutory language in 38 U.S.C. 1110 as not precluding a veteran from receiving compensation for an alcohol or drug-abuse related disability secondary to a veteran's service-connected disability or use of an alcohol or drug abuse disability as evidence of the increased severity of a service connected disability.

In our view, payment of additional compensation based on the abuse of alcohol or drugs is contrary to congressional intent and is not in veterans' best interests because it removes an incentive to refrain from debilitating and self-destructive behavior. Moreover, the court's interpretation in *Allen* could also greatly increase the amount of compensation VA pays for service-connected disabilities. This potential is illustrated by mental disorders, which are frequently associated with alcohol and drug abuse. The legislation we are seeking would avoid those increased costs by clarifying that compensation is not payable for disability that is a result of the veteran's own alcohol or drug abuse, even if the abuse is secondary to a service-connected disability.

Question 41: The proposed budget anticipates significant savings if Congress adopts the proposal referenced in Question 40. What assumptions were made in arriving at the savings VA projects? Are there particular drug or alcohol abuse-related disabilities which would account for the bulk of the savings? Irrespective of whether physical disability—e.g. liver damage—is manifest on account of drug or alcohol abuse, does VA consider physical dependence on alcohol or drugs a disease?

Answer: The potential costs of the *Allen* v. *Principi* decision were determined using the following assumptions:

At the time of the estimate there were over 2.3 million veterans in receipt of service-connected disability compensation. Approximately 750,000 Vietnam veterans were on the rolls and the substance abuse for this population was noted to be 44.9 percent (approximately 340,000 veterans). Incidence rate of substance abuse for the general population is 32.6 percent. We subtracted the number of Vietnam veterans from the total veteran population and applied the 32.6 percent substance abuse rate to the remaining veteran population (approximately 510,000 veterans). Therefore the pool of potential veterans is approximately 850,000. A claim rate of 30 percent was assumed for the first year with a 25 percent grant rate.

Specific disabilities were not considered in making this estimate. While the Merck Manual cites the four most common forms of organ damage resulting from alcoholism as cirrhosis, peripheral neuropathy, brain damage, and cardiomyopathy, there are many other conditions that can be attributed to chronic alcoholism. The disabilities resulting from drug abuse also vary widely.

Question 42: The proposed budget requests an extension of the Veterans Advisory Committee on Education, set now to terminate on December 31, 2003. What action has VA taken in the last three years as a result of Advisory Committee recommendations?

Answer: The Department of Veterans Affairs has supported and given strong consideration to a vast majority of the Veterans Advisory Committee on Education (VACOE) recommendations. VACOE is effective in formulating recommendations and advising the VA on significant veterans' issue.

VACOE has made many recommendations that require legislation. We take these recommendations into account when we provide our views to Congress on bills under consideration.

These recommendations are also reviewed when we are helping draft the Administration's veterans bill. VA cannot always adopt Advisory Committee recommendations, either because of budget limitations or other pressing veterans' issues.

VA has acted on the following recommendations:

2001:

Improve interdepartmental coordination of veteran-related issues.

• VA expanded the working relationship and liaison with Department of Defense by taking part in the Montgomery GI Bill (MGIB)-Active Duty, MGIB-Selected Reserve and DoD Voluntary Education policy working groups. VA provided MGIB usage and budget trend analysis to DoD and the military services. In addition, we provided policy advisories and guidance, previously only provided to our regional offices, to Department of Defense and Military Service points of contact which has im-

proved the level of understanding of MGIB education programs in the military community.

• VA partnered with the Department of Labor, Veterans' Education and Training Service (DOLNETS) to sponsor, Transition Assistance: The Role of Certification Second Annual Conference. This conference addressed the role of certification in the transition from military to civilian employment. In 2002, VA and DOLNETS partnered to sponsor Transition Assistance: The Role of Certification "Military Training to Career Success."

The VACOE recommended a web-based secure portal for Education Service.

• The Loan Guaranty Service is developing a web portal that will be available for use by the Education Service. The portal will provide an efficient mechanism for information exchange and access to the Education systems by veterans and other stakeholders, such as schools, State Approving Agencies, etc.

VACOE recommended that staffing at RPOs be at an appropriate level.

• Education Service has evaluated staffing levels at RPOs to ensure that they are adequate.

2002:

VA should use its authority to make sure accelerated payment is widely available.

• VA published regulations on accelerated payments in the Fall of 2002. These regulations will ensure that accelerated payment is widely available.

Question 43: I note a significant downward adjustment to expected education claims for licensing and certification tests. Why is demand for education benefits to train for such tests low? What more can be done, if anything, in terms of outreach? Are service members departing the military made aware of the various uses of their education benefits?

Answer: The downward adjustment to the expected education payments for licensing and certification tests is based on an incorrect assumption made during the last budget cycle. We assumed more veterans would want to be reimbursed for the licensure and certification tests they took. Instead they apparently do not want reimbursement for lower cost tests. During FY 2002, the first full year of authority to provide reimbursement for qualifying tests, VA made 5,111 payments, and the average payment was approximately $280. This figure was much lower than the 25,000 payments projected for fiscal year 2002, in the 2003 budget. However, the demand for test reimbursement continues to grow through the first five months in 2003, almost doubling the number of payments made over the same period in 2002.

In terms of additional outreach, VA is currently contracting with a news distribution company to create a news release about the Licensing and Certification program. The company provides these stories to thousands of newspapers, radio stations and television stations. This news release should be available to media outlets in June 2003.

Service members departing the military receive a transition assistance briefing which covers their education benefits, to include licensure and certification test reimbursement. In addition, we are beginning to distribute pamphlets to all service members who are within six months of discharge. Pamphlets were sent to about 55,000 service members in late April 2003.

Question 44: Public Law 107-103 expanded the work-study program to include work performed at VA nursing homes and hospitals, and work at State and national veterans' cemeteries. How many work-study contracts have been approved for work at these new sites?

Answer: VA nursing homes, hospitals, and cemeteries have been eligible to use VA Work-Study students for many years and have taken advantage of the program. VA hospitals, which include the VA nursing homes, use a great many VA work-study students.

We polled VA work-study coordinators and have confirmed the employment of nine VA Work-Study students at State veterans' cemeteries.

Question 45: How many individuals were served through the VR&E program's independent living program in each of fiscal years 2000, 2001, and 2002? What were VA expenditures for the program in each of those fiscal years? What is the projected caseload and related expenditures for fiscal years 2003 and 2004?

Answer: Veterans receiving support through VR&E's Independent Living Program for fiscal years 2000 through 2002 number as follows:

• FY 2000—2,530
• FY 2001—4,247
• FY 2002—5,650

Average 12-month Independent Living Program caseloads for fiscal years 2000 through 2002 are as follows:

• FY 2000—1,231

- FY 2001—2,270
- FY 2002—3,209

Numbers of veterans to be served through the Independent Living Program for fiscal years 2003 and 2004 are projected as follows:

- FY 2003—5,444 veterans
- FY 2004—5,220 veterans

We are unable to provide the fiscal information you requested at this time. In September of 2001, VR&E deployed Corporate WINRS, VR&E's Information and Case Management System. In February 2002, the WINRS modifications were put in place to enable us to separately account for independent living expenditures and training expenditures in the readjustment benefits (RB) account (similar to the way general operating expense funds are tracked). We will be able to provide this accounting information for FY 2003 at the end of this year.

Question 46: Does the decline in FTE specified in the budget for the loan guaranty program factor in the result of VA's recently completed housing program's A-76 study? If not, how many FTEE will be eliminated when property management functions are contracted out?

Answer: The President's FY 2004 budget requests DoD direct FTE for the Loan Guaranty Program. This level of FTE is required to support the Loan Guaranty benefits delivery functions and the property management oversight function in FY 2004. Over the 3 percent years of the A76 Property Management (PM) Study, the majority of the PM employees found other positions in anticipation of the loss of the PM functions to the private sector or were lost to retirement or buyouts. Any remaining PM employees will be reassigned to fill other critical Loan Guaranty vacancies or other available positions in regional office operations once the PM contract is activated. No additional FTEE below the DoD level will be eliminated when the PM functions are performed by the contractor.

Question 47: The proposed budget projects that three loans will be disbursed in FY 04 under the Guaranteed Transitional housing for Homeless Veterans loan program. The total amount of the loans is expected to be $20 million, while the subsidy costs associated with the loans are expect to be $9.7 million. Why is the subsidy cost so high for this program? Is this one reason VA proposes to make this a grant program?

Answer: The subsidy rate originally selected for the Multifamily Transitional Housing Program was the subsidy rate of what was thought to be a comparable housing program. Every effort will be made to reevaluate the subsidy rate with more program specific assumption data. As is true with all credit reform programs, the projected costs (subsidy) of the program are only as valid as the assumptions used to project the subsidy rate. Should this loan guaranty program remain as originally authorized by Public Law 105-368, VA will be evaluating all available prospective borrowers proposals to estimate the risk of the proposals and develop revised assumption data. VA is currently negotiating with Bearing Point (formerly KPMG Consulting) for ongoing assistance with areas such as underwriting to assist VA with the credit standards VA should use in evaluating the credit-worthiness of prospective borrowers.

VA has found that many potential developers of transitional housing are in need of a cash grant or other sources of funds that do not require regular repayment. Based on numerous discussions with potential developers, VA has concluded that a grant would be of more benefit to such developers than a loan.

The key advantage for the Federal government of changing from a guaranteed loan to a grant program is the reduction of financial loss resulting from loans defaulting. The current pilot program, as a loan guaranty, is full of risks (pre-development, construction, operating risks) and currently has a subsidy rate of 48.25 percent. The potential sponsors could apply for grant funding, in lieu of a loan guaranty, where repayment is not required.

The proposal to convert this loan guaranty to a grant program resulted after VA's experience in trying to design the loan guaranty program and meeting with potential partners under this pilot program. In addition, numerous representatives of government, private and public lending institutions, and real estate developers of multifamily housing projects have advised VA of the high risk involved and high rates of defaults by borrowers.

Veterans could be better served with the proposal to change from a loan guaranty to a grant program because VA believes more developers would be interested in and able to complete projects with the assistance of a grant rather than a loan that must be repaid. Therefore, there exists the likelihood that more projects will be completed and more beds will become available to homeless veterans if this program were converted to a grant.

Question 48: What is VA's strategy for addressing the $280 million worth of "one-time repairs" identified in volume two of the *Study on Improvements to Veterans Cemeteries*?

Answer: The National Shrine Commitment report, completed last year, provides a comprehensive assessment of the condition of the Department's national cemeteries. The report identified over 900 projects at a cost of nearly $280 million to ensure a dignified and respectful setting appropriate for each national cemetery. The Department of Veterans Affairs (VA) will use the information and data provided in the report to plan and accomplish the repairs needed at each cemetery.

The report includes an extensive database of condition assessment information. This data will be used in the planning process to assist in prioritizing repair projects over a multi-year period. VA will evaluate the problem categories and the severity of problems within each category. VA will also use data from the Annual Survey of Satisfaction with National Cemeteries to factor in the viewpoint of veterans and their families when determining project priorities.

Repairs to address long-standing deferred maintenance needs will be addressed in a variety of ways. Gravesite renovation projects to raise, realign and clean headstones and markers and to repair sunken graves will continue to be a high priority in allocating operational resources. Infrastructure improvements to buildings, roads, irrigation systems and historic structures will be addressed with capital expenditures through the major and minor construction programs. In addition, cemetery staff will be used to complete some repairs.

A preliminary review of the report's findings indicates that the contractor has recommended some repair processes and solutions that are significantly different from those currently used by VA. In some cases, particularly headstone and marker cleaning, VA methods are more cost effective. VA will evaluate the long-term benefits of the contractor's recommended processes to determine the best solution for achieving the same results.

It is important to note that except in very few cases are the repair projects identified in the study truly "one-time repairs". The care and maintenance of cemetery grounds and facilities is cyclical in nature and require continuing efforts. This is especially true for the maintenance of burial sections and the cleaning and realignment of headstones and markers. VA will develop strategies and plans for preventive maintenance to address these and other recurring issues related to the appearance of national cemeteries. VA will also use in its planning processes recently developed operational standards and measures by which actual achievement to national shrine standards can be compared or measured on a proactive, ongoing basis. VA will develop the additional mechanisms necessary to ensure that the data collected are accurate, valid, and verifiable.

Question 49: The proposed budget requests almost $25 million for expansion and improvement of the Fort Snelling National Cemetery. The justification given for the request is that Fort Snelling will exhaust burial capacity for both casketed and cremated remains by 2007, leaving approximately 280,000 Minneapolis-area veterans without a cemetery within reasonable driving distance. If that is the case, why is Minneapolis not on the list of locations identified in the Future Burial Needs report?

Answer: *The Future Burial Needs* report identified those areas of the country with the greatest concentration of veterans whose burial needs will not be served by a national or State veterans cemetery from 2005 through 2020. The report also anticipates that undeveloped land at a national cemetery would be used to develop additional gravesites to extend service to veterans. Fort Snelling Cemetery was not identified in the report because it has undeveloped land that will provide gravesite capacity beyond 2030. The major construction project included in the 2004 budget request reflects the Department's practice of phased development of open national cemeteries as the need approaches.

Question 50: In your testimony, you established a performance goal of marking 75 percent of graves in national cemeteries within 60 days of interment. How long does it currently take to mark a grave after interment in a national cemetery? To what do you attribute the delay?

Answer: In 2002, the Department of Veterans Affairs (VA) began to measure the timeliness of marking graves in national cemeteries. The baseline data showed that 49 percent of graves in national cemeteries were marked within 60 days of interment. It is VA's goal to increase the percent of graves marked within 60 days to 75 percent by 2004. Significant progress has already been made towards achieving the 75 percent goal. Performance has improved from 49 percent to 64 percent through the first 5 months of fiscal year 2003.

There are many factors that affect the timeliness of setting headstones and markers in national cemeteries. A business analysis has identified the key processes involved from the interment to the actual marking of the grave. These processes in-

clude preparing the inscription for the headstone or marker, contracting, manufacturing, shipping, and setting the delivered headstone or marker on the gravesite. Each of these processes will be evaluated at the Central Office and cemetery levels. Significant progress has been achieved at some cemeteries simply by reducing the cycle time for releasing orders to contracting or by changing operational practices in how headstones are set in burial sections. VA will also examine how cycle time may be reduced by modifying the contract specifications used for the production and delivery of grave markers to the national cemeteries.

The VA plan for continuous performance improvement will focus on reengineering current business processes in the ordering and setting of headstones and markers and enhancing management oversight. The importance of marking graves in a timely manner will continue to be emphasized through monthly performance and accountability reviews. Top management involvement is essential for success. New tracking reports and analytical tools will be developed to assist managers in identifying opportunities for improvement. The establishment of performance goals and holding managers accountable for results will increase VA's ability to meet the performance goal.

Question 51: VA is updating its future cemetery construction plan based on data from the DoD census. When does VA expect to release the updated plan? What assumptions about cemetery access do you expect the new plan will make?

Answer: The VA Office of the Actuary has recently completed revised veteran population estimates, based on DoD census data. The National Cemetery Administration is currently using this data to develop revised veteran population estimates for the 31 sites identified in the Study on Improvements to Veterans Cemeteries, Volume 1—Future Burial Needs. This information will be provided as soon as VA completes its review. This update will provide the revised veteran population estimates within the context of current policy on cemetery access and other service delivery factors. VA will continue to evaluate these factors in its planning process to ensure the Department is effectively meeting the burial needs of veterans.

Question 52: Please provide a report on VA's progress, and costs, in establishing a new national cemetery in Atlanta. Please include in that report: an accounting of costs incurred to date in the construction of that cemetery; an itemization of costs VA anticipates will be necessary to complete that cemetery project; and VA recommendations, if any, with respect to this project.

Answer: The proposed new national cemetery, located in Cherokee County, Georgia (about 35 miles north of Atlanta), is projected to accommodate over 65,780 interments from 2005 through 2035. The first phase of the project will develop approximately 23,000 gravesites for casket interments, 3,000 columbarium niches, and 500 in-ground sites for cremated remains. This first phase of construction will develop about 110 acres and will provide burial capacity for approximately 10 years, through 2015. The use of extensive pre-placed crypts will greatly increase the capacity for burial sites per acre, and the use of columbaria will provide extensive capacity for cremated remains while using less land. In addition to gravesite development, the first phase will include an entrance area, a flag/assembly area, three committal service shelters, a public information center with restrooms, an administration and maintenance complex, road system, utilities, signage, site furnishings, fencing, and landscape plantings.

In choosing a site for the Atlanta national cemetery, VA followed its standard procedures for identifying those sites that would be suitable for development as a cemetery. VA collaborated with private and other government entities to identify a multiple number of possible sites. Once several sites were identified, the site evaluation team considered a wide variety of factors when surveying the site's potential, such as proximity to veterans, topographical features, sufficient acreage size, and the surrounding land use. Once the number of sites was narrowed down to the most favorable, VA considered the suitability of the land for development as a cemetery. This step always involves conducting an environmental assessment.

The choice to select the current site was ultimately based on its meeting certain evaluation criteria as well as the fact that there would be no acquisition costs. The site was donated to the VA saving the Federal Government approximately $4.5 to $6.5 million, based upon comparable commercial sites that were considered. There are always benefits and challenges with any site being considered. For example, while the site ultimately chosen posed challenges in terms of topography, its location near main roadways will make it more easily accessible to the veteran population it serves. By accepting the donated site and precluding lengthy assessments, price negotiations, and the associated need for an additional appropriation request for land purchase, progress toward developing a new national cemetery to serve area veterans was accelerated by potentially one full year.

Costs to date for this project include $100,000 for conducting the Environmental Assessment, $1.1 million for master planning and design development, and $1.2 million for preparation of construction documents. In addition to Federal funding, funding has been provided from the local government—Cherokee County approved the generous expenditure of $1.0 million in County funds to help develop an access road to the new national cemetery. VA has provided $1.4 million to augment the County's funding in order to complete the entry road. Construction of the entry roadway should be completed by Fall 2003. The State of Georgia Department of Transportation is also providing improvements, estimated to be $250,000 to $500,000, to State Route 20 that serves as primary cemetery access.

VA received $28 million for the construction of this new national cemetery in the FY 2002 appropriations act. The prospectus for this project and detailed cost estimates were included in the FY 2002 President's budget request. The VA will be able to develop the first phase of this cemetery within the amount appropriated.

VA is committed to completing Phase 1 of this project because it believes the overriding factor should be the provision of effective service to the veteran. In the future, before further phases are developed, VA will assess the cost effectiveness of continuing to expand the current site versus other viable sites in the area that would be more cost effective.

Question 53: The proposed budget recommends an 11 FTEE increase within the Office of the Secretary for the Office of Regulation Policy and Management. The budget mentions that the office was modeled after similar offices in other cabinet-level agencies. Which other cabinet agencies have such offices and how many FTEE are in each?

Answer: The Federal Government's most active rulemaking agencies are HHS, USDA, EPA, DOI, DOT, DOC, HUD, VA, and DOJ. The Department of Veterans Affairs' Office of Regulation Policy and Management is an amalgamated model designed to capture the "best" features and avoid some of the known problems experienced by these agencies, and others. Major General Walt Huffman, who proposed our current structure, met with various regulatory officials and incorporated important concepts from DOT, DOL, and the USCG. We anticipate that our single, centrally located office, will assure timely and effective rulemaking. Its process for producing new regulations creates accountability for regulation development.

Based upon the number of regulatory reviews OMB performed on rules they deemed to be significant, over a 3-year period (see *www.whitehouse.gov/omb/library*, for 1999 to 2001 statistics), coupled with information obtained informally from each agency's rulemaking staffs, we estimated the following: HHS averaged 108 significant regulations per year with a staff in excess of 50 FTEE; USDA averaged 74 significant regulations per year with a staff ranging from 20 to 30 FTEE; EPA averaged 64 significant regulations per year with a staff of 20 FTEE; DOI averaged 46 significant regulations per year with a staff of 30 FTEE; DOT (including the USCG) averaged 44 significant regulations per year with a staff ranging from 20 to 30 FTEE; DOC averaged 40 significant regulations per year with a staff of 14 FTEE; HUD averaged 36 significant regulations per year with a staff of 10 FTEE; VA averaged 34 significant regulations per year with a staff of 7 FTEE (now 11 FTEE; and 3 supporting FTEE attorneys in OGC); and DOJ averaged 28 significant regulations per year with an estimated staff of 15 to 25 FTEE. It is important to note that each agency also publishes hundreds of less significant regulations and notices that are not reviewed by OMB because they are not considered "significant" under OMB guidance.

The FTEE numbers were difficult for agencies to quantify because each agency is configured differently. Some have decentralized operations. Many employees often perform rulemaking functions in conjunction with other duties. Some regulatory offices performed enforcement, legislative, or administrative law functions as well as rulemaking activities. Many organizations have a large number of employees who draft regulations infrequently or only on a part-time basis. Most offices had lawyers dedicated to the rulemaking process and many regulation offices were located within the General Counsel's organization. However, we concluded that centralized control, early policy integration, and uniform processing of VA policies and regulations could be more effectively accomplished by operating under the Secretary. DOI's Office of Executive Secretariat and Regulatory Affairs also operates under the authority of the DOI Secretary.

Question 54: The Board of Veterans' Appeals (BVA) is now permitted to develop evidence and correct procedural defects in lieu of remanding claims. Given the increased responsibilities, one would think an increase in staffing was warranted. However, the budget projects a decrease in FTEE for BVA in fiscal year 2004. How without an increase in staffing, will BVA be able to reduce appeals resolution time

and keep its own backlog of cases on the appellate docket from getting out of control?

Answer: In February 2002, the Board of Veterans' Appeals (BVA or Board) was provided with the authority to develop evidence and to cure procedural defects in order to improve appeals resolution time. While the Board retained the authority to remand appeals for the originating agency to take such action, remands had the effect of significantly increasing appeals resolution time, as there has been a significant delay, on average, between the time of the remand and its return to the Board. For example, in FY 00, this time averaged 627 days. We believed that, ultimately, the Board would be able to achieve a final resolution of an appeal in a more effective and timely manner by doing the necessary development itself in most cases.

As the Board had not had this responsibility in the past, the proper staffing levels and other resource requirements to successfully accomplish the mission were difficult to determine at the outset. The proper staffing levels and productivity performance measures for this activity and for the Board as a whole are currently under active consideration by the Department.

The Board instituted and had plans to institute a number of administrative measures designed to improve decision timeliness within its current resource allocation. For example, the Board improved administrative efficiency by restructuring along functional lines. In order to better serve our Nation's veterans and their families, our Chairman requested and our staff responded to increase productivity—our Veterans Law Judges increased their productivity by 25 percent, and our staff counsel have done so by 20 percent. We are continuing to improve our case tracking system and measures of performance to improve individual and organizational accountability. In addition, together with the Veterans Benefits Administration and the Office of the General Counsel, we have expanded Department-wide training and other initiatives to improve the quality and timeliness of the entire appellate process. Other initiatives to improve efficiency and timeliness using existing resources include: a pilot project to utilize computer assisted transcription to improve the processing time for hearing cases, the preparation of draft designations of the record by paralegals instead of attorneys, and the use of cost effective intern and extern programs.

In a decision issued May 1, 2003, the United States Court of Appeals for the Federal Circuit invalidated the VA regulation authorizing the Board to develop evidence. *Disabled American Veterans et al.* v. *Secretary of Veterans Affairs*, Nos. 02-7304, 7305, 7316 (Fed. Cir. May 1, 2003). The Department is currently evaluating the impact of this decision.

Question 55: What accounts for the near 300 FTEE difference between what the fiscal year 2003 budget estimated for the Office of Human Resources and Administration and what the current estimate is?

Answer: Early in fiscal year 2003, the Shared Services Center (SSC) in Topeka, KS was realigned under the Veterans Health Administration (VHA). The decision to terminate the HR LINK$ development project resulted in a drastically re-scoped mission for the SSC that is best housed in VHA. The re-constituted office is now known as the Health Revenue Center. This decision resulted in approximately 270 FTE being transferred from the rolls of HR&A to VHA.

Question 56: One of the duties of the Office of Congressional and Legislative Affairs (OCLA) is to "identify, track, and coordinate the development of all congressionally mandated reports. . ." Has OCLA produced a database of all mandated congressional reports that includes status information on each report? If not, will you direct OCLA to produce such a database by the end of fiscal year 2004?

Answer: During 2002, the Office of Congressional and Legislative Affairs (OCLA) was proactive and completed a Department-wide centralized listing for all congressionally mandated reports. The database was developed as a tool to track all reporting requirements and place all VA elements on at least a 90-day advance notice of due dates of the congressional deadline. The database successfully integrated and contains newly enacted provisions from the 107th Congress, consolidates requirements of both the authorizing and appropriating Committees and updates automatically (rollover feature) for cyclical recurring reports. Reports may be standardized to provide information on those completed, past due or coming due in 30, 60, or 90 days or within any specified date range. Customized reports may also be run to target specific deadlines or topics in the completed, past due or coming due categories.

In addition, the integrity of the reports data are being annually reviewed by OCLA and all program offices responsible for preparing congressionally mandated reports.

The goal is to maintain the quality of the data so that the reports system produces useful and beneficial reports to assist VA in meeting deadlines.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN NIGHTHORSE CAMPBELL TO HON. ANTHONY PRINCIPI

Question 1: Many veterans are blaming Congress for the enrollment cuts for not providing enough money. I understand the difficulty of looking into the future and trying to predict the numbers of enrollees and determine the inflationary costs of health care. Yet in each of the last two years, Congress has appropriated more than the budget request. The VA's inability to predict its needs and make accurate projections has been enormous. What are you doing to do to change that? How can the VA better project and anticipate its needs for vets' medical care?

Answer: VA's ability to estimate veteran demand and expenditures has improved significantly with the use of an actuarial health care demand model. This model is based on private sector benchmarks adjusted for our veterans' age, gender, morbidity, utilization, reliance, and insurance. The model projects veteran enrollment, utilization, and expenditures, and includes detailed projections for approximately 50 health care service categories.

While this change to using actuarial projections in budget development now allows us to provide very accurate estimates of expected enrollment and expenditures, it also quantifies the escalating demand for veteran health care. In comparing the expenditures projected by the model for FY 2003 and 2004 with our anticipated resources, we identified a significant gap between veteran demand for health care and those resources. It was also clear that continued workload growth of the magnitude experienced in recent years is unsustainable in the current federal budget climate. Therefore, using the model, we developed health care policies to reduce veteran demand and expenditures and close the gap.

Even with the suspension of Priority 8 enrollment, the actuarial projections show that the increasing demand placed on the VA health care system will continue to strain VA's ability to provide timely, high-quality health care for veterans in Priorities 1-6. VA expects to provide health care to 3.6 million patients in Priorities 1-6 in FY 2004, an increase of 5 percent over FY 2003. Priorities 1-6 alone are expected to cost $9 billion more by FY 2008 compared to FY 2003.

The suspension of Priority 8 enrollment and the policies proposed in the FY 2004 budget are designed to ensure that VA is able to fulfill its core mission—providing timely access to high quality health care to veterans with service-connected disabilities, low incomes, and those with special needs.

Question 2: Mr. Secretary, the last time we visited, you said that the Denver Vets Medical Center move to the Fitzsimmons campus in Aurora was still under consideration, and that the Air Force might join the collaboration. Can you update us on that situation?

As you know, the entire Colorado delegation supports that move. How do you see us helping to make that move a reality?

Answer: Dr. Roswell, the Under Secretary for Health, participated in a meeting on January 3, 2003, with leadership from DOI to discuss the current status of the VA/DoD joint venture project at the Fitzsimons site. It was agreed that a joint VA/DoD task group would be convened to begin their deliberations. On January 15, 2003, Dr. Roswell convened a work group to examine, explore, and define long-term requirements for veterans in the Denver area. This included developing and evaluating proposals for VA/DoD/University of Colorado partnerships. The group was to consider, among other things, the impact to the CARES process and identify a plan for appropriately involving stakeholders. The VA task group has met and completed a draft options paper. Further discussions and more specific and detailed information are also under development.

In early February, Mr. Dennis Brimhall, President of the University of Colorado Hospital, met with Dr. Roswell and committed to providing a response on what mechanism the University could use to make land available to VA for a VA outpatient clinic and bed tower footprint. James Floyd, Chairman of the VA work group, held a meeting on March 13, 2003, with DOI representatives near Buckley Air Force Base in Denver. Colonel Stephen Meigs, Command Surgeon, Buckley Air Force Base, who will continue to serve as the primary DOI contact in Denver, also attended the meeting. The meeting included discussions of both VA and Air Force needs and resources and used the recently completed Air Force economic analysis of the joint venture possibilities. Colonel Meigs has indicated that moving VA to Fitzsimons fits into their long-range plans. The meeting discussed an integration plan that would include ambulatory and inpatient care for active duty, dependents, and possibly retirees. The joint venture group will work over the next several weeks to develop a draft proposal of services.

Chairman SPECTER. Thank you very much, Mr. Secretary. The committee is very appreciative of your service, your background, your work for this committee in the past, and what you have done for the veterans.

I begin with this issue of the suspension of enrollments of Priority 8 veterans and ask you, why is that necessary?

Secretary PRINCIPI. Sir, the growth in workload has far outstripped our capacity to provide the care in a timely quality manner. As I indicated, we have grown from 2.9 million to 6.8 million in just a relatively short period of time, and we are not meeting the expectations of the veterans who are currently enrolled because of the long waiting lists that have resulted from our inability to match resources and demand.

And the Congress directed that I make an annual enrollment decision, and Priority 8, of course, is the lowest priority in terms of not having any military-related disabilities and higher incomes. And I believe that a suspension of enrollment was the responsible thing to do until such time as we can get our hands around this backlog and begin to meet veterans' expectations.

It was a difficult decision. The easy one, the politically expedient one, would have been for me to keep the doors open. But that would have resulted in long delays, not high quality of care, and I just felt that it was not the appropriate thing to do.

And as you indicated, Mr. Chairman, we are on the verge of another war. We have a responsibility to ensure we have the capacity to treat men and women who may be disabled, if we do go to war. And we have a provision that allows any service member who serves in a combat theater of operations, including reserve and guardsmen, to have eligibility for VA health care within 2 years from returning from a combat zone.

So I think it is the responsible thing to do, the difficult thing to do. But it will allow us to focus on our core constituency, the disabled and the poor.

Chairman SPECTER. Mr. Secretary, you have stated publicly before the Omnibus Appropriations Act was enacted that if the VA were to receive an increase of $2.5 billion for fiscal year 2003, the VA would be able to eliminate first appointment backlogs. You did get that amount of money. Will you be in a position to make good on that pledge or expectation?

Secretary PRINCIPI. Yes, sir. I can assure you that, you know, short of some unexpected development that might occur, how this war might impact on the VA if, in fact, there is a war, we are prepared to utilize those resources to totally eliminate the backlog by October, this coming October.

Chairman SPECTER. When we speak of backlogs, Mr. Secretary, what about the backlog in the litigation line and the various chains of litigation? What is the situation now with respect to the adjudication backlog in the Veterans Benefits Administration and in the various levels of the appellate process?

Secretary PRINCIPI. Referring to the disability claim backlog, Mr. Chairman?

Chairman SPECTER. Yes.

Secretary PRINCIPI. Sir, we began the calendar year with a backlog of 432,000 claims for disability compensation and pension, what

we call rating-related claims, the kind of claim that your dad may have filed for disability compensation.

We have brought that down now to close to 300,000 claims in the inventory, notwithstanding the fact, Mr. Chairman, that each and every month we get about 60,000 new claims in. So we are making dramatic progress.

We created a Tiger Team in Cleveland supported by nine other offices around the country. And their purpose in life is to address the claims of our elderly veterans, primarily veterans over the age of 70 who have been waiting more than a year for a decision.

And since the Tiger Team has been in effect, along with the nine resource centers, we have decided 77,000 claims. That is 77,000 veterans who had been waiting a long time for a decision. I think most of those decisions are favorable. But in any event, it is a decision that a veteran can appeal if he is not happy with it.

Chairman SPECTER. Mr. Secretary, you are asking that there be legislation imposing an annual enrollment fee of $250 for veterans with over $24,644 a year. How much money do you expect to take in on that?

Secretary PRINCIPI. Our expectation is in excess of $100 million a year. I think we projected $111 million a year in enrollment fees.

You know, and I know you would certainly agree with me and chastise me if I said we are talking about high-income veterans because $24,000 is, indeed, not a very high income. But we are trying to at least put a little bit more burden on those who may have some other options and who can most afford to pay a little bit for the cost of their care.

On average, we spend about $2,000 a year on health care for each veteran. So this represents slightly more than 10 percent of the cost of their care. But it will generate about $111 million.

Chairman SPECTER. You have also asked for legislation for increased pharmacy co-payments from $7 to $15 for a 30-day supply, again with the figure of $24,644. How much will that be expected to yield?

Secretary PRINCIPI. That we expect will yield $183 million in 2004.

Chairman SPECTER. Mr. Secretary, why do you pick a figure of $24,644 as a cutoff point for the enrollment fee and the increase in pharmacy co-payments?

Secretary PRINCIPI. That is statutory, sir. That is set by law, the different categories. And at Priority Group 7, it is my understanding that that is in the law for a single veteran. It is about $28,000, I believe, for a veteran who has one dependent, married. But that is a statutory requirement.

Chairman SPECTER. Well, this is going to require legislation in order to carry these ideas out. As long as it is statutory, we could change that. It seems to me that $24,644 is a very, very modest level.

Secretary PRINCIPI. It is. That is something that we certainly can work on, Mr. Chairman, to look at the income levels, to ensure that it is fair.

And Congress last year established a new Priority Group 8, and that is more of a geographic means-tested priority group. We can

look at the Priority 8s, which I think is averaged about $35,000 a year, somewhere in that neighborhood.

But certainly, sir, we could look at the income levels to ensure that whatever assessment is being made is at a level that veterans can most afford.

Chairman SPECTER. Mr. Secretary, with respect to Medicare subvention, I am advised that as to Category 8, if the individuals are not accepted at the VA but choose Medicare, that there can be some compensation from CMS which runs back to VA. How would that work?

Secretary PRINCIPI. Sir, I am very pleased that Secretary Thompson and I have been able to kind of break down the barriers that all too often have prohibited collaboration between VA and HHS. We need to do a lot with DoD, too. But we have agreed conceptually that any veteran in Priority Group 8 who, because of that suspension, cannot get care through the VA and is Medicare eligible would be going out on fee-for-service. So there is a cost to the trust fund, clearly.

So we worked toward establishing what we call a VA+Choice program, something akin to a Medicare+Choice program. So that any Category 8 veteran, Medicare eligible, who would like to come to the VA and get their care would be able to enroll in this VA+Choice program, and we would be their Medicare provider.

And we would provide them with a range of health care services, including prescription drugs that they cannot currently get under Medicare. And we would be reimbursed from the Medicare trust fund on a capitated basis, risk-adjusted, so that we have a new source of revenues to the VA.

Chairman SPECTER. My red light is on, but I just want to finish up this line of questioning before yielding to Senator Bunning.

How many of the Category 8 veterans will that cover? It covers all of those over 65. How many others in Category 8 are there?

Secretary PRINCIPI. Dr. Roswell perhaps can——

Dr. ROSWELL. Mr. Chairman, there are approximately 9 million veterans age 65 and over. Almost half of those are in Priority 7 and 8, and the majority of those in Priority 8. We anticipate that there are close to 4 million veterans over age 65 who, by virtue of age, are Medicare eligible.

Chairman SPECTER. In Category 8?

Dr. ROSWELL. In Category 8.

Chairman SPECTER. How many under 65?

Dr. ROSWELL. There are, of course, anyone under 65 that is Medicare eligible is by virtue of disability. If they are a veteran and disabled, the majority of them would already be eligible by virtue of their disability.

Chairman SPECTER. Well, would they be in Category 8?

Dr. ROSWELL. Probably not. That is my whole point. They would probably be in a higher——

Chairman SPECTER. How many in Category 8 are there under 65 who are not disabled who qualify for a different category?

Dr. ROSWELL. I am not sure I have that number.

Chairman SPECTER. Well, in Category 8, you eliminate VA care. But the people 65 and over——

Dr. ROSWELL. Can still get it.

Chairman SPECTER.——can come to the VA, and Medicare will pay for them. How many people in Category 8 are under 65, so that Medicare would not pay for them?

Dr. ROSWELL. I understand. Approximately half of those in Priority 8 are Medicare-eligible by virtue of age. So approximately the same number——

Chairman SPECTER. And half of them would be not eligible. They would be under 65.

Dr. ROSWELL. Ineligible for Medicare.

Chairman SPECTER. Well, if you went to Category 7 or Category 6 and you got VA to pay for those 65 and over, wouldn't that be a big help to the VA budget?

Secretary PRINCIPI. Well, the only way——

Chairman SPECTER. Work out that deal with other categories?

Secretary PRINCIPI. It would be, except the only way it works for HHS from an actuarial perspective on the trust fund is if they are no longer eligible for VA health care. So the only time that this—the only way this program works and we could get HHS to agree was to say that they are not eligible for VA health care.

They are Medicare eligible, and they are going to go out on fee-for-service. So the trust fund benefits by having them enroll, if they wish, into a VA+Choice program. So it would mean that Category 6s and 7s would no longer be able to enroll in order for HHS to provide us with the benefit.

Chairman SPECTER. Well, my red light is on.

Senator Bunning.

STATEMENT OF HON. JIM BUNNING,
U.S. SENATOR FROM KENTUCKY

Senator BUNNING. Thank you, Mr. Chairman. And I have an opening statement.

Chairman SPECTER. Without objection, it will be made a part of the record.

Senator BUNNING. Thank you. Mr. Secretary, I applaud your efforts to reduce wait times for medical appointments and processing times for benefit applications. But when I talk to veterans in Kentucky, the top concern I hear from them is how long they have to wait.

I told them I would take this up with you the next time I saw you. The next time I talk with the veterans of Kentucky, what do you want me to tell them about the delays at VA?

Secretary PRINCIPI. Well, you can tell them that this Secretary is very, very concerned about those delays and believe we are doing something about it.

The appropriation, which the President signed into law yesterday, gives our health care system an additional $2.6 billion in funding for the balance of this fiscal year, although later than we would have hoped. It is going to allow us to increase our staffing, nurses, physicians, expand our outpatient clinics so that we can begin to make real inroads in ensuring that they get in to see a doctor within a reasonable period of time.

And it is my goal, Dr. Roswell's goal, that we are going to eliminate the backlog by the end of this fiscal year. And we are going to monitor that very carefully, and you tell them that I intend to

be held accountable. We are going to do what we can to get them in.

Senator BUNNING. I assure you, Mr. Secretary, you are going to be held accountable, whether you like it or not.

I served as Chairman of the Social Security Subcommittee in the House of Representatives on Ways and Means, and SSDI people were backed up to the tune of about 30,000. And I don't know if the veterans are as in as bad a shape as the SSDI program in the Social Security system.

The other question I hear quite often from veterans in Kentucky is about VA clinics. Veterans in Kentucky love them, and the communities love them. Many communities in my State want clinics. Some even have offered to donate space to locate the clinics. I recognize that your top priority is and must be to improve existing services. There is no point in adding services that cannot be adequately provided.

When initiatives to reduce medical appointment wait times are successful, will you be open to expanding the current network of community clinics, especially in communities that are willing to contribute to the clinics themselves?

Secretary PRINCIPI. Yes, Senator, we are beginning to look at lifting the moratorium on opening new community-based outpatient clinics. We have opened some 664 in recent years. That has accounted for a good deal of the increased workload because now veterans have an access point close to their home. They don't have to drive long distances to Lexington and other VA medical centers.

So we are going to begin the process of identifying those areas where we need to expand, and we will do so.

Senator BUNNING. Well, people in Ashland and people in places like that in Kentucky either drive to Columbus or drive to Lexington, which is a long way off. And whatever you can do to alleviate that problem, we would certainly appreciate it. Especially as far as pharmaceuticals and drug care, they really need that assistance.

And I will be looking and watching very closely to see that you accomplish your goals.

Secretary PRINCIPI. Thank you, sir.

[The prepared statement of Senator Bunning follows:]

PREPARED STATEMENT OF HON. JIM BUNNING,
U.S. SENATOR FROM KENTUCKY

Thank you, Mr. Chairman.

This Committee has quite a full slate of hearings over the next few weeks, but this one stands out the most. Not only do we have the Secretary and other officials from the V.A., but we also have representatives from many veterans groups.

As I mentioned yesterday, I am glad to sit on this Committee at this time. In the Omnibus Appropriations Bill we passed a few weeks ago, V.A. medical care received an unprecedented $2.5 billion increase. That is an 11 percent increase, which is truly remarkable in the current budget situation.

Another large increase has been requested for next year, and I support further increases, especially for health programs. As a member of the Budget Committee, I will be involved in the process at every step along the way.

However, I think everyone in this room recognizes that money will not cure all the problems at the V.A.

Mr. Secretary, wait times must be reduced for appointments. Claims processing must be made faster.

Our veterans are grateful for what the V.A. does right, but the V.A. must also be held accountable for what it does wrong. I am committed to holding the V.A. accountable and will work with this committee to do so.

Thank you, Mr. Chairman.

Senator BUNNING. [Presiding.] Thank you.

Senator Akaka.

STATEMENT OF HON. DANIEL K. AKAKA,
U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you. Thank you very much. I would like to take this opportunity to express my appreciation and welcome to you, Mr. Secretary, and the staff here.

As I have said since your confirmation, your job is not an easy one, and particularly I want to offer my warm welcome, Secretary Principi, to you and my best wishes in all that you do.

Secretary PRINCIPI. Thank you, sir.

Senator AKAKA. I want you to know that I understand that you will continue to make the very difficult decisions you have to make because of fiscal limitations imposed upon your agency. However, this does not alleviate my concerns about the need for improved access to health care for veterans and improvements in services and benefits for veterans.

In addition, I remain very concerned about the decision to end enrollment for Priority 8 veterans. I am also fearful that the scant amount of funding for emergency preparedness will preclude VA from fulfilling its role in the event of a catastrophic event.

As I have said before, your job is a tough one, but you are more than qualified to deal with these challenges, and I look forward to continuing to work with you, Mr. Secretary.

I also welcome your distinguished staff, Dr. Roswell, Secretary Cooper, Secretary Benson, Secretary McClain, and Secretary Campbell.

I also want to welcome the second panel, Mr. Wilkerson, Mr. Cullinan, Mr. Surratt, Mr. Blake, and Mr. Jones, who represent American Legion, Veterans of Foreign Wars, Disabled American Veterans, Paralyzed Veterans of America, and AMVETS.

Your contributions to this process are vital to our ability to meet the needs of our veterans.

I thank you for your dedication and commitment to improving the quality of life for the men and women who have served to defend our country.

Mr. Secretary, last year, I expressed my concern for Priority 7 vets paying more toward their deductible, because I was concerned about how this would impact access to health care. As you know, I am concerned about the decision to end enrollment for Priority 8 veterans.

After reviewing the fiscal year 2004 budget, I note that serious work is still needed regarding access to health care for veterans. In addition, the budget proposes increases in the prescription drug co-payment and the outpatient co-payment.

My question is what would be the impact on your budget if the increases in co-payments were not implemented?

Secretary PRINCIPI. Well, there would be a significant impact on the department. There would be about a $200 million and $181

million—there would be about a $400 million total impact on our budget if we did not get the authorities to increase the co-pays and the annual enrollment fee.

What it would mean is we couldn't care for as many veterans. I think what happened is—and I certainly don't take exception to what happened in 1998—but you know, prior to 1998, approximately 2.3 million of the 25 million veterans in this Nation were eligible, not entitled, to the comprehensive health care system. Only 2.3 million were eligible for outpatient care. You had to have a service-connected disability, primarily.

The law on eligibility reform changed that. So we went from 2.3 million eligible to 25 million eligible. That is a big jump. And since 1998, that, coupled with the wonderful prescription benefit that we have that is not available to veterans or any American under Medicare, the outpatient clinics that Senator Bunning talked about, that we have built across the country—664 of them.

And truly, this is not my dad's VA. This is a high-quality VA health care system today affiliated with our medical schools.

The demand has jumped from 2.9 million that we were seeing in the VA to 6.8 million enrolled today, and with no signs of any abatement. And what concerned me was that the men and women who were disabled in uniform, the people who took a bullet in the spine or lost their legs, were being a little bit squeezed out of the system because we had a lot of Priority 8s and 7s who were coming to get their prescription drugs.

And we just didn't have the money. I don't know how else to say it.

The demand was far outstripping our ability to fund it. And Congress said, "Mr. Secretary, you are only authorized to provide health care to the extent resources are made available to you in appropriation acts. And accordingly, you must make an annual enrollment decision." That was set up by law, and the priority scheme was set up by law.

So I am trying to balance the needs of the poor, the service disabled, and those in need of spinal cord injury treatment and, of course, see as many other veterans as possible. But there came a point where I said I had to make an enrollment decision. I had to say we had to suspend those who might have other options because they have higher incomes and they have no military-related disabilities.

I certainly didn't like making that decision. It wasn't politically easy. But it was the right decision. And that is where we are.

Senator AKAKA. My time has expired.

Secretary PRINCIPI. Excuse me. And I might only just add that that is not to say that the President and the Congress have not been very generous. The President and the Congress of the United States have been very generous. The $2.6 billion that we just received yesterday is extraordinary—I don't think we have ever received that much before, either in real or relative terms.

Again, it is just the fact that the growth demand is just outstripping our ability to provide the care. And that is what caused the decision to be made.

Senator AKAKA. Thank you.

Senator BUNNING. Mr. Jeffords.

STATEMENT OF HON. JAMES M. JEFFORDS,
U.S. SENATOR FROM VERMONT

Senator JEFFORDS. Mr. Secretary, I very much thank you for braving the snow to come up here and join us today.

Secretary PRINCIPI. It is always a pleasure, sir.

Senator JEFFORDS. Today, this Nation finds itself on the brink of war. If nothing else, the fact alone should focus our minds on the needs of veterans. I am shocked and saddened to hear from my VA facilities in Vermont about the struggle they engage in daily in an effort to provide veterans with the care they deserve.

This is not right. Veterans should not have to wait more than half a year for an appointment to see a doctor. We can do better, and we must do better.

You have been a leader on these issues for many years. We need your leadership in the fight to fund the health care system that veterans deserve.

I heard your statement, and I just want to get to the budget for this year. I appreciate the fact that you have fought hard for full funding for the veterans health care. But I am very concerned that the 2003 budget is not adequate to meet the needs of veterans this year. As I understand it, it is the shortfall in funding that precipitated the decision to no longer provide care for non-service-connected, non-indigent veterans who are not currently enrolled in the VA.

I am very concerned about this decision and very worried that the current budget will force many facilities to cut back their services to veterans. This could not come at a worse time for many vets. Do you have any plans this fiscal year to alleviate these projected shortfalls?

Secretary PRINCIPI. Senator Jeffords, again, I think that the $2.6 billion increase this year, it is going to go a long way. Again, you know, I would have preferred to have it in October, and not February or March, so that we could have started ramping up to hire the doctors and the nurses and the technicians that we need to man the facilities in Vermont and Nebraska and Kentucky, across the country, Hawaii and Pennsylvania.

But the fact is, we have the money now, and treatment and getting veterans off the waiting list is our highest priority. And the message has been delivered across the system by Dr. Roswell and myself, and we are going to monitor it daily, if necessary, to ensure that veterans are getting in to see the doctors.

But, again, Senator, if we get a prescription drug benefit this year, a Medicare prescription drug benefit, that may help us because many of the veterans are coming to us strictly for pharmaceuticals. They have a physician in the private sector, but you know, they need—they don't have prescription drugs. And that is causing somewhat of this backlog and these waiting times.

So we do have a plan. We are going to aggressively implement the plan. And I am confident that by the end of the year, you are going to see this backlog eliminated, and that is our plan.

Senator JEFFORDS. I would like to turn, just for a moment, to the subject of long-term care. This is something that the committee has been active on for the past few years. And members intend to continue advocating for adequate provisions for this valuable benefit.

I am very concerned about the proposed limitation in the institutional long-term care benefit because the VA has not yet sufficiently developed the capacity to provide non-institutional alternatives. The millennium bill provisions mandated that the institutional benefit could be limited only when the ability to provide other forms of long-term care was provided to all who qualify.

What measures are you taking ensure that the VA's non-institutional capacity will be adequate to meet the foreseen demand particularly as you intend to limit eligibility for nursing homes?

Secretary PRINCIPI. Senator Jeffords, let me just begin and then perhaps turn it over to Dr. Roswell.

I can assure you we are not lessening our commitment to long-term care. Over the past 8 years, we have added almost a billion dollars to the State Veterans' Home Program. We have funded most of the 20,000 beds in the State Nursing Home Program. We will continue the main institutional capacity in the VA.

I think what we are trying to do is recognize that long-term care services have changed dramatically. And with geriatric primary care, with home-based primary care, with adult daycare, with respite care, and hospice care that we can do so much more and reach so many more veterans in a setting, their home, that is more conducive to the kinds of care that they would like. They would like to stay in their home as long as possible.

So I think it is a balancing, if you will, sir. It is not to say that institutional care is not important because you reach a point in life where you may need to be institutionalized. But with a limited budget, we are trying to say let us take advantage of the advances in technology, the ability to provide more care at home.

And our goal by 2007 is to increase the average daily census. We have increased it from 11,000 to 16,000 in the past 3 or 4 years. Our goal is to increase it to 35,000 average daily census in community and home-based long-term care by 2007. So we do have a plan, and that is what we are trying to do.

But believe me, it is not lessening, because while the veteran population by the end of this decade will go down 18 percent, 2010, the number of veterans over the age of 75 will increase by 12 percent, and those over 85 will triple.

So we are on the cusp of this real elderly veteran population. We are out in front of the general population by about 20 years, and we need to be prepared to meet that demand.

Senator JEFFORDS. Thank you, Mr. Secretary. I know you will try your best, and I just wanted to alert everyone to this serious problem.

Secretary PRINCIPI. Yes, sir. It is a critical issue.

Chairman SPECTER. [Presiding.] Senator Nelson.

STATEMENT OF HON. E. BENJAMIN NELSON,
U.S. SENATOR FROM NEBRASKA

Senator NELSON. Thank you, Mr. Chairman.

Secretary Principi, it is good to see you. I have enjoyed working with you and have been continually impressed by the level of your personal commitment as well as professional commitment to our veterans.

Secretary PRINCIPI. Thank you, sir.

Senator NELSON. And I greatly appreciate your efforts on behalf of Nebraska's veterans. I want to thank you again publicly for joining me in Nebraska last year at a field hearing regarding the merger of VISN's 13 and 14.

It is also good to see so many representatives from our veterans' organizations. I know that you all make a difference and you continue to represent your various groups.

My question today is, Mr. Secretary, at the time of our budget hearing last year, it took, I think the number was 219 days on average, to decide a benefits claim. And then the latest numbers indicate that it still takes about 201 days to decide a claim.

But if the target for the end of the year is still 100 days, the question is with the best efforts, how can you achieve and maintain that goal with the flat-lined budget request and, in fact, one that will actually maybe cut some compensation and pension staff? Maybe you could help me on that?

Secretary PRINCIPI. I sure can, Senator, and it is a question that I certainly—and an issue I watched very carefully. We are making progress. And I think the reason that it has not come down faster is because my focus and that of Admiral Cooper is to decide the oldest claims first.

We had a backlog of claims that were languishing for a year, two or three years. Now, they don't count against your timeliness until you decide them. So, you know, you can have perfect timeliness in this business by never deciding the older claims, you know? Just decide the ones that are a couple of days old or a month old, and let the poor veterans, the older veterans with old claims just languish. And that is what was happening.

So over the past year-and-a-half, we created this Tiger Team to say let us get these claims of veterans over the age of 70 who have been waiting a year for a decision, get them decided. So that has kept our timeliness up over 200 days.

I am concerned about hitting 100 days. We are doing great in bringing the backlog down. We are going to hit my goal of 250,000 claims. But we have some work cut out for us in getting that number down to 100 days. But I think that as soon as we get rid of this large number of old claims and start deciding those that are 30 days old and 60 days old, you will see that amount come down pretty quickly.

Senator NELSON. Okay. I am also pleased that last year the VA Nurse Recruitment and Retention Act of 2001 was signed into law, because you know the VA is the largest employer of nurses.

And with the nursing shortage everywhere across the country, I am very concerned about what your capacity will be to hire nurses.

And given the fact that because of the reserve and call-up and the need for more nurses in the military, given the build-up for Iraq, it is only going to make it that much more difficult to find nurses. You are not going to be any different than any other health institution in doing that.

Do you have a plan in particular that might help address that shortage, given the circumstances?

Dr. ROSWELL. Senator Nelson, we do have a comprehensive plan. We had a multidisciplinary effort last year to produce a document called "A Call To Action." It identified over 70 strategies to enhance

the professional practice environment for VA nurses as well as a variety of recruitment and retention strategies.

Some of those require policy actions that are now being implemented. Others require legislation. And later this year, we will submit a comprehensive pay reform proposal that will allow us to enhance our ability to recruit and retain both nurses, as well as physicians, who, I might add, haven't had a pay raise since 1991 in the Department of Veterans Affairs.

So your point is very much on target. We recognize that to be able to eliminate the backlogs that Senator Jeffords and other members have talked about, we now have to expand our workforce, and that means hiring doctors and nurses. We anticipate that through the end of the 2004 budget year, we will have added over 2,500 nurses and over 1,300 physicians to our workforce.

We will also add licensed practical nurses and nursing assistants to bring that total workforce increase among doctors, nurses, and the nursing discipline up to over 4,000 additional employees. But it will take the pay reform package that we will be submitting later this year. And we certainly look forward to your support for that.

Senator NELSON. Well, I appreciate it, Dr. Roswell. And I thank you, and I wish you the best of luck in doing that. Our Nation's veterans really do need it, and I know that you are committed to making that happen. We obviously are very anxious to work with you to make sure that it does, in fact, happen.

Thank you very much.

Secretary PRINCIPI. Thank you, Senator Nelson. Appreciate it, sir.

Chairman SPECTER. Mr. Secretary, just a couple more questions, and we will move to panel two.

There has been some issue raised as to whether many of the VA enrollees are really interested in the availability of drugs at the cost the VA can provide. Has any consideration been given to allowing veterans to have the drug benefits without being enrollees generally?

Secretary PRINCIPI. Yes, Senator. It is an issue that we are grappling with very intensely. You know, part of me says, why are we duplicating the consumption of resources by, you know, if a patient—a veteran has a Medicare doc, and the doctor gives him prescription——

Chairman SPECTER. After you have had those conversations with yourself, why not?

Secretary PRINCIPI. I don't know where it would lead, Senator. Quite honestly, I am concerned that if we just started filling prescriptions that those veterans across the country who are not using the VA system and need prescription drugs would overload the system at the VA and that we would be diverting resources from primary care and tertiary care just to essentially be a drugstore.

And it is really the cost issue and the workload demand issue that causes us some hesitation to move down that road at this point in time.

Chairman SPECTER. Could you have a pilot project to test it out to see what the impact would be?

Secretary PRINCIPI. Well, we have talked about that, and we have worked up a pilot program. It would require, I am told, legis-

lation because we don't have the authority. It is something that our general counsel and the committee counsel can look at. It is something that we have talked about to do a pilot project and to see if it would work.

Obviously, I think once we went down that road and it was successful, it might be very difficult to stop, like most things in town. But it is something we can certainly look at.

Chairman SPECTER. A couple of provincial questions. How are we doing on a cemetery for eastern Pennsylvania?

Secretary PRINCIPI. We are certainly spending a lot of time talking about it.

[Laughter.]

Secretary PRINCIPI. Mr. Benson, who has been up there——

Chairman SPECTER. That is a good specific answer.

[Laughter.]

Secretary PRINCIPI. There is clearly a need for a national cemetery in the Philadelphia area. Our current guidelines of 75 miles and 170,000 population in the catchment area, that portion of Pennsylvania falls out a little bit.

But it is something under serious consideration, Mr. Chairman, and we believe that a national cemetery is necessary in that area to meet the interment needs of the veterans of Pennsylvania.

Chairman SPECTER. And when will the CARES issue be done, so we can focus on getting the additional construction in Lebanon, Pennsylvania?

Secretary PRINCIPI. The under secretary is to submit his report to me by June 1st. We have a commission established that is going to review that report and get back to me for a final decision on October 1.

Chairman SPECTER. Does anybody else have any additional questions?

Senator Bunning?

Senator Jeffords?

Senator Nelson?

Well, thank you very much for coming in, Mr. Secretary.

Secretary PRINCIPI. Thank you, Mr. Chairman.

Chairman SPECTER. You have got a big job ahead of you, and we will be cooperating with you.

Secretary PRINCIPI. Thank you so much, sir.

Chairman SPECTER. We will now call panel two. We will take a very brief recess before panel two comes in.

[Recess.]

Chairman SPECTER. Well, thank you very much for joining us, gentlemen. These are the veterans service organization witnesses, and we are very pleased to have you here. We thank you for your participation.

And can we close that door, please? Anybody who wants to hear the pearls of wisdom emanating from this room must come inside.

[Laughter.]

And besides that, it is too noisy out there. But as I was saying, we thank you for your participation and for your ombudsman function in looking after the veterans. It is a major job, and one of our key congressional responsibilities is oversight. And candidly, it is very hard to do with all of the other commitments which we have.

So we rely on the service organizations to serve as, in effect, ombudsmen. Their reviewing of VA activities and their assistance to us in providing some oversight of VA is very, very helpful.

On the witness list given to me, determined by staff, which makes most of the important decisions on Capitol Hill—I'm just kidding about that—they don't.

[Laughter.]

But they do list the witnesses.

Our first witness is listed as Mr. Philip Wilkerson for The American Legion. He is responsible for overseeing the American Legion's claims and appeals services in Washington, and the program of annual technical training for the Legion's professional service officers. He is a native of Washington, DC, a graduate from American University in 1963, attended Navy OCS, served aboard the USS Cambria from 1963 to 1967.

Welcome, Mr. Wilkerson, and we look forward to your testimony.

Mr. WILKERSON. Thank you very much, Mr. Chairman.

Chairman SPECTER. I regret the limited time. But in setting the time, I just want to tell you there was a memorial service for Ambassador Walter Annenberg recently in Philadelphia, and the time limit was set at 3 minutes. And that applied to President Ford, and Secretary of State Colin Powell, and Arlen Specter, and 14 other people who testified. So I want you to know that on the 3-minute allocation, you are on a par with Ford, Powell, and me.

[Laughter.]

Let us start the clock again for Mr. Wilkerson.

STATEMENT OF PHILIP WILKERSON, DEPUTY MANAGER FOR OPERATIONS AND TRAINING, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. WILKERSON. Thank you very much, Mr. Chairman. It has been a while since I have been before this committee, and I always appreciate the opportunity to present the views and concerns of the American Legion.

For VHA for fiscal year 2004, the request will require the continued rationing of health care. While the proposed additional staffing and resources may enable VA to meet its stated goal of focusing on its core patient base, this, however, can only be achieved if some 1.2 million other veterans are effectively forced out of the VA system.

VHA has, over the past several years, encouraged veterans, including those who are military retirees and Medicare-eligible, to enroll for VA medical care. This effort has been so successful that medical centers across the country are now under-funded and ill-equipped to handle the large influx of veterans seeking all types of care.

During the same period, the American Legion has become increasingly concerned by veterans' complaints of problems in obtaining needed medical care and unacceptably long waiting times. Our national commander, Ronald Conley, has confirmed these problems in his visits to a number of medical centers across the country.

The American Legion is adamantly opposed to VA's efforts to overturn the mandate for improved long-term care set forth in Pub-

lic Law 106-117 by counting non-VA sources as part of VA's capacity. We believe the ability of the VA medical centers to achieve current medical care collection fund goals will be severely constrained by the restriction on the enrollment of new Priority 8 veterans and will also impact the facilities' ability to meet the higher fiscal year 2004 goals.

We continue to advocate that all MCCF collections be treated as an addition to the discretionary appropriation without an offset. In addition, VA should be authorized to seek reimbursement from Medicare without offset as a way to help meet its long-term funding needs.

The American Legion is also concerned that VHA's net funding request is contingent upon several budget proposals that seek to generate additional revenue for VA directly from veteran patients rather than through appropriated funds.

We are opposed to denying enrollment to new Priority 8 veterans. It does not make good business sense to us to keep out patients that VA could otherwise be billing directly or indirectly for the cost of their care.

We certainly believe that this is the wrong message to be sending to our men and women who are on active duty and being sent in harm's way, who will eventually be returning to civilian life.

We once again wish to express our strong objection to the proposed $250 enrollment fee, and we hope that Congress will once again reject this concept as they did last year with the proposal of a $1,500 deductible.

While the American Legion applauds reduced pharmacy co-pays, we do not support shifting the cost of this change to the back of Priority 7s and 8s. With regard to VBA operations, we believe the straight-line staffing request for the C&P and the Board of Veterans Appeals is a grave concern. There is an exception, however, to the increase that will be provided to the education service.

Mr. Chairman, in the coming months, it will be imperative that Congress critically evaluate the funding needs for VHA, for VBA, and the Board of Veterans Appeals. The American Legion looks forward to working with you and the members of the committee.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Wilkerson follows:]

THE PREPARED STATEMENT OF PHILIP WILKERSON, DEPUTY MANAGER FOR OPERATIONS AND TRAINING, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to express the views of the 2.8 million members of The American Legion regarding the Department of Veterans Affairs' (VA) Fiscal Year (FY) 2004 budget request. As veterans' advocates, it is our job to ensure that VA is funded at a level that is adequate to fulfill the mandate "—to care for him who has borne the battle, his widow and his orphan."

With this budget request, President Bush and Secretary of Veterans Affairs Principi clearly state their objective: "a continued focus on the health care needs of VA's core groups of veterans—those with service-connected disabilities, the indigent, and those with special needs." The American Legion believes there are two ways to achieve this goal:

- Rationing of health care by driving veterans away from the health care system designed to meet the health care needs of America's veterans or
- Expand the health care system to meet their health care needs without compromising the quality of care.

For over a decade, The American Legion has advocated allowing veterans to spend their health care dollars to the health care system of their choice. The American Legion believes the Veterans Health Administration (VHA) can efficiently expand to meet the health care needs of the men and women who have honorably served this Nation in its armed forces—in war and in peace.

The American Legion believes the level of funding proposed in the FY 2004 budget request may meet the President's goals, but will lead to over 1.2 million veterans leaving the system. The American Legion also has reservations about the budgetary impact on other aspects of VA operations, to include the Veterans Benefit Administration (VBA).

When Congress opened access to the VA health care system, many veterans believed VA was their best health care option and voted with their feet. Since the Centers for Medicare and Medicaid Services (CMS), the Nation's largest public health insurance program, does not offer its beneficiaries a substantive prescription program, many Medicare-eligible veterans chose to enroll in VHA specifically to receive quality health care and access to an affordable prescription program. Since the Department of Defense (DoD), TRICARE, and TRICARE for Life require military retirees to make co-payments or pay premiums, but does not provide for specialized care (like long-term care), many military retirees also chose to enroll in VHA.

Veterans continue to suffer as a result of a system that has been routinely underfunded and is now ill equipped to handle the large influx of veterans waiting to use their services. Veterans continue to endure interminable waiting times for medical appointments, as well as unacceptably long waiting times for claims adjudication.

VA essentially entered FY 2003 without a budget. Continuing to operate at an inadequate FY 2002 funding level has presented many challenges. The fallout, in part, has been the Secretary's decision to suspend enrollment of Priority Group 8 veterans for the foreseeable future. Clearly, the current system is fiscally tapped out.

The problems resulting from years of under funding run even deeper within the VA health care system. In October 2002, National Commander Ronald F. Conley began an initiative to reach out to the hundreds of thousands of veterans who actually make up the VA health care backlog. Through surveys asking veterans for their comments regarding their experience with the local VA Medical Center (VAMC), The "I Am Not A Number" Campaign, as it has been dubbed, has allowed The American Legion to learn first-hand of the problems that exist when seeking health care through VA.

The problems described in these surveys, coupled with the information that has been gathered from Commander Conley's visits to over 25 Veterans Affairs Medical Centers (VAMCs), has been less than encouraging. VAMCs are expressing their concern over the significant increases in their Medical Care Collection Fund (MCCF) goals for FY 2003 and what impact the recent restrictions on enrolling any new Priority Group 8 veterans will have on their ability to meet those goals. Prohibiting the one Priority Group of veterans that, most likely, has an expendable income and has third-party health coverage to help VAMCs meet increased MCCF goals seems, at face value, illogical.

Many VAMCs are using capital improvement funds to pay for the delivery of health care. Facility improvements continue to be delayed due to budgetary shortfalls. National Commander Conley is learning first hand of VAMC concerns over the outsourcing of services and the cost effectiveness of this initiative.

The growing shortage of medical specialty personnel, nurses in particular, is continuing to impact the delivery of quality health care. Exacerbating this shortage is the real possibility of National Guard and Reserve units being activated, since several thousand VA personnel are members of the Guard or Reserve and their activation would certainly have a negative impact on the operation of the VAMCs.

The American Legion believes these issues and others will continue to plague VA beyond FY 2003. As we turn to FY 2004, the picture is no brighter. The American Legion believes any budget for VA should be augmented by MCCF and not scored as an offset to a budget, because these reimbursements are paid for the treatment of non-service-connected medical conditions. When VA distributes its annual appropriations to each Veterans Integrated Service Network (VISN) it uses a Veterans Equitable Resource Allocation (VERA) formula. There are many components to this formula, to include the patient population of Priority Groups 1-6, but the number of enrolled Priority Group 7 and 8 veterans is not a funding or distribution factor. Therefore, a VISN is not funded to treat Priority Group 7 and 8 veterans, but must seek co-payments and third-party reimbursements to cover the cost of care. These collections should be added to the discretionary appropriations, not subtracted from these limited resources.

EMPLOYMENT ISSUES

The 2004 budget theoretically provides for the medical care and treatment of over 820,000 inpatients with an average daily census of over 57,000. VA expects an increase in the workload in 2004 and subsequently has requested an additional 5,029 Full Time Employees (FTE). The American Legion's concern lies in the fact that they are decreasing staff in institutionalized care and using that decrease to increase numbers of staff in other areas, in essence, robbing Peter to pay Paul.

The lack of certified coders is another important employment issue. Indian Health Services stressed the importance of having certified coders with regard to accurately and quickly collecting third-party reimbursements. If the coders are not well trained, the chances of costly mistakes are high. The problem with getting certified coders is that the Office of Personnel Management (OPM) will not authorize these positions for VA or Indian Health Services. The American Legion believes this is short-sighted. VA increasingly relies on their third-party reimbursement collections. It would make sense to authorize the use of certified coders.

The American Legion is curious as to how many VA vocational readjustment clients are being trained to be certified coders or for that matter adjudicators. We believe training individuals in these critical skills could help VA meet its own employment needs, but also help place disabled veterans find meaningful employment.

MEDICAL CARE

The VA health care delivery system is not only the largest health care provider in the Nation, but it has established itself as a formidable leader in the health care industry. Veterans receive quality health care and are choosing VA as their health care provider in record numbers. VA is currently struggling to meet their needs and, with VA's proposed FY 2004 budget, it will continue to struggle.

The FY 2004 budget request introduces several proposals to generate increased revenues from the pockets of veterans through an enrollment fee, co-payments and third-party reimbursements. According to VA, these proposals will reduce the resource demand by $1.3 billion collectively and hopefully encourage 1.2 million veterans to leave the system. The budget request also seeks management savings of over $1.1 billion. This adds up to a $2.4 billion offset to the requested $25.4 billion budget for medical care.

The American Legion is concerned with several of the budget proposals:

• *Limit enrollment*—VA proposes to continue the suspension of enrollment of new Priority 8 veterans. These veterans have incomes above $24,644 for a single veteran and above the Housing and Urban Development (HUD) geographic means test level, to include non-compensable, zero percent service-connected veterans. Although these service-connected veterans may seek health care for their service-connected disability, they are prohibited from enrolling for treatment of or prescriptions for any non-service-connected medical conditions.

The American Legion continues to disagree with this recent decision. We believe denying veterans' access to VA health care, particularly while we prepare to go to war, is unacceptable. Many recently separated veterans would fall into this Priority Group. By denying health care to Priority Group 8 veterans, VA is sending the message that these veterans are not welcomed, even if they have the expendable income or private health insurance coverage that VA can bill for the cost of their non-service-connected medical treatment. Clearly, there are potential Priority Group 8 veterans with no health care coverage because they are self-employed or unable to afford premiums.

In order for more veterans to access VA health care, additional revenue streams must be generated to supplement the discretionary funding. The American Legion strongly advocates Congress authorize VA to bill, collect, and retain third-party reimbursements from CMS for treatment of Medicare-allowable, non-service-connected medical conditions of Medicare-eligible veterans. Since Medicare is a Federally mandated, pre-paid health insurance program, The American Legion believes Medicare-eligible veterans should be allowed to choose their health care provider.

To qualify for Medicare, most veterans make automatic monthly payroll deductions to CMS and cannot use the benefit until reaching age 65. Access to VHA health care is based on honorable military service not age; therefore, a veteran earns the right to enroll in VA, but is forced, by law, to participate in Medicare. There is a clear difference here: VA is a health care provider, while Medicare is a health insurer. If VA is a Medicare-eligible veteran's health care provider of choice, then VA should be reimbursed for providing quality health care services.

• *Assess an annual enrollment fee*—VA proposes a $250 annual enrollment fee for non-service-connected (NSC) Priority 7 veterans and all Priority 8 veterans. Priority 7 veterans have incomes above $24,644 for a single veteran and below the HUD geo-

graphic means test level, to include non-compensable, zero percent service-connected disabled veterans.

This annual enrollment fee would apply even if the veteran has third-party health insurance that reimburses VA for the treatment of non-service-connected medical conditions. This annual enrollment fee would apply even if the veteran was willing to make co-payments for treatment of non-service-connected medical conditions, pharmacy, and specialized care (like long-term care). However, this annual enrollment fee does not guarantee timely access to quality health care. According to President Bush and Secretary Principi, these veterans are not their primary focus.

The American Legion cannot support this proposal because it is designed to discourage the enrollment of veterans based solely on their income and not their honorable military service. There are Priority Group 7 and 8 veterans with military awards and decorations for wartime service that, for the grace of God, were not seriously wounded. Many members of "The Greatest Generation" fall into these Priority Groups. Many veterans of the "Forgotten War" fall into these Priority Groups. This cannot be the intent of a grateful Nation—to nickel and dime veterans out of their heath care system.

The American Legion would urge Congress to reject this proposal just as it did the Administration's plan last year to charge Priority Group 7 veterans a $1,500 deductible.

The American Legion will continue to work with Members of Congress to pass long-term funding solutions. We will continue to fight for Medicare reimbursement legislation that will allow Medicare to pay VA for the cost of health care it provides to all Medicare-eligible veterans. Further, we will continue to advocate mandatory funding legislation for the President's and Secretary Principi's core constituents.

Access to quality health care is a continuing struggle for veterans seeking care through VA. Continued budgetary shortfalls, combined with rising medical care costs and increased demand for care have resulted in unprecedented waiting times.

• *Change the veteran's share of outpatient and pharmacy co-payments*—This proposal entails reducing the pharmacy co-payment burden for Priority 2-5 veterans, while increasing Priority 7 and 8 pharmacy co-payments from $7 to $15. It also increases outpatient primary care co-payments from $15 to $20 for all Priority 7 and 8 veterans.

While The American Legion applauds the reduction of the pharmacy co-payment for veterans in Priority Groups 2-5, the recent increase in co-payments from $2 to $7 was accompanied by a decrease in the outpatient co-payment from $50 to $15. Obviously, this means the President and Secretary of VA miscalculated the reasonable charge for medications and treatment. The American Legion would rather VA seek reimbursements for CMS for all enrolled Medicare-eligible veterans being treated for non-service-connected medical conditions, before trying to balance the budget on the backs of Priority Groups 7 and 8 veterans.

• *Require reimbursement for services provided to health maintenance organization and preferred provider organization members*—This proposal seeks to establish VA as a preferred provider for members of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPO's) would obligate these organizations to reimburse VA for health care provided to their members.

The American Legion believes this change would help VA increase third-party reimbursements. The fact that VA currently cannot bill HMO's and PPO's is unfair considering VA treats many veterans who belong to these organizations. The American Legion would welcome this change; however, it seems odd to mandate private sector insurance plans to recognize VA as a preferred provider and not mandate CMS to recognize VA as a Medicare provider, especially since VA meets or exceeds most of CMS' own quality performance standards. If CMS' goal is to provide its beneficiaries with the best quality health care, VA should be a recognized Medicare provider. In fact, CMS Director Scully claimed before the Presidential Task Force To Improve Health Care Delivery for Our Nation's Veterans (PTF) that he encourages veterans to go to VA rather than private health care providers.

• *Change the institutional long-term care services provided to veterans*—This proposal would allow non-institutional, as well as, institutional workload in community and State Home Nursing programs along with VA Nursing to count toward the 1998 capacity level. VA would supposedly expand their total long-term care capacity by increasing non-institutional long-term care.

The American Legion believes the proposal will further stagnate long-term care services. The passage of the Veterans Millennium Health Care and Benefits Act (Public Law 106-117) on November 30, 1999, was the first step toward ensuring a comprehensive long-term care plan for veterans. The American Legion fully supported this insightful decision by Congress, especially with the aging veterans' population. It required the VA to bring the census back to 1998 levels. So far they have

failed to do that. VA has the authority to establish co-payments for non-service-connected veterans in need of long-term care—a time in their lives when they and their families desperately need help from VA. The President and the Secretary want to reduce the number of long-term care beds without any recommendations from the PTF or the Capital Assets Realignment for Enhanced Services (CARES). In fact, the CARES process is currently not addressing either long-term care or mental health inpatient needs. The "market plans" currently being developed by each VISN will not be including institutionalized care involving long-term care or mental health. The American Legion cannot accept this recommendation.

The American Legion is committed to developing permanent solutions to preserve and improve the VA health care system. This goal includes providing a coordinated continuum of long-term cares to meet the needs of the individual veteran. With the ever-growing aging population of veterans, it is critical that VA positions itself to adequately care for all the needs of these veterans, to include long-term care.

The American Legion recommends $24.5 billion for direct medical care in FY 2004; however, strongly recommend to add, rather than offset, MCCF and authorize VA to bill, collect, and retain third-party reimbursements from the Nation's largest health insurance program—Medicare—for the treatment of non-service-connected medical conditions on a fee-for-service basis.

MEDICAL AND PROSTHETIC RESEARCH

VA's Medical and Prosthetic Research Program (R&D) is the premier research initiative leading the Nation's efforts to promote the health and care of veterans. The mission of R&D is to "discover knowledge and create innovations that advance the health and care of veterans and the Nation." R&D has been instrumental in advancing treatments for conditions such as prostate cancer, diabetes, heart diseases, mental illnesses, spinal cord injury (SCI) and aging related diseases, conditions directly related to veterans.

The Quality Enhancement Research Initiative (QUERI) continues to be a top priority issue for R&D. QUERI is a multidisciplinary, data-driven national quality improvement program. There are eight QUERI groups that work to promote "putting research results to work" and to measure the impact of that research at all levels. These groups are chronic heart failure, diabetes, HIV/AIDS, ischemic heart disease (IHD), mental health, SCI, stroke and substance abuse. Additionally, The National Cancer Institute is funding a new Cancer QUERI. These initiatives focus on veterans' health issues and have already had a profound effect on improving the care and rehabilitation of the Nation's veterans.

Two of the biggest challenges facing R&D are facility infrastructure and recruitment and retention. Like the rest of VHA's buildings, research facilities are in desperate need of repair. They have been neglected over the years due to budgetary constraints. Currently, R&D has nearly 30 facilities in varying states of disrepair. The condition of these facilities directly impacts the recruitment and retention of qualified researchers. The ability to maintain a state-of-the-art facility is vital to retaining talented and motivated researchers.

In the wake of the September 11th terrorist attacks and their aftermath, there has been a renewed focus on bioterrorism research and VHA's fourth mission, which is to support DoD during a national emergency.

The accomplishments of the VA research program cannot be overstated. The program has been recognized both nationally and internationally for its efforts toward the betterment of veterans' lives and advances in their health care. Without proper funding the program cannot possibly maintain its current level of success. The American Legion believes VA's budget request for $408 million is inadequate. The American Legion recommends $445 million for medical and prosthetic research in Fiscal Year 2004.

MEDICAL CONSTRUCTION AND INFRASTRUCTURE SUPPORT
MAJOR & MINOR CONSTRUCTION

Over the past several years, The American Legion has testified on the inadequacy of funding for VA's major and minor construction programs. Buildings continue to be neglected and the persistent deterioration results in unsafe environments similar to conditions discovered last year at the VAMC in Kansas City, Missouri. Of course, those that pay the price of this neglect are the veterans who are receiving care at these facilities.

Year after year, needed projects are not funded, because the money is just not there. A 1998 study conducted by Price-Waterhouse recommended that VA fund 2 percent to 4 percent of Plant Replacement Value (PRV) per year and to reinvest in new facilities to replace aging facilities. The conclusion of this analysis was that

VA's reinvestment rate of .84 percent was significantly lower than the benchmark of 2 percent. That equates to hundreds of millions of dollars that conceivably could be used for major construction projects. Private consultants have been warning for years that dozens of VA patient buildings were at the highest level of risk for earthquake damage or collapse, yet funding continues to be woefully short of what is actually needed to correct this problem. The President's budget request of $422 million falls well short of funds needed to ensure the safety of the Nation's veterans.

The American Legion recommends $320 million for major construction and $240 million for minor construction to make a combined total of $560 million.

GRANTS FOR THE CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The State Veterans Home Program is an important adjunct to VA's own nursing, hospital and domiciliary programs. The American Legion believes it must continue, and even expand, its role as an extremely vital asset to VA. This program has proven to be a cost-effective provider of quality care to many of the Nation's veterans.

As many VA facilities reduce long-term care beds and VA has no plans to construct new nursing homes, State veterans' homes must absorb a greater share of the needs of an aging population. Title 38, United States Code (USC) authorizes VA to pay 65 percent of the total cost of building new veterans' homes.

The American Legion recognizes the growing long-term health care needs of older veterans and would like to reemphasize the essential service that the State Veterans' Home Program provides to these veterans. The program is a viable and important alternative health care provider to the VA system. The American Legion recommends funding of $115 million for this program.

NATIONAL CEMETERY ADMINISTRATION (NCA)

The National Cemetery Administration (NCA) honors veterans with a final resting-place and lasting memorials that commemorate their service to the Nation. More than two million Americans, including veterans of every war and conflict—from the Revolutionary War to the Gulf War—are honored by burial in VA's national cemeteries. Nearly 14,000 acres of land are devoted to this formidable mission.

As a result of the continuing increase in veterans' deaths, NCA is constantly seeking burial space. Total interments for NCA are projected to significantly increase over the next five years, peaking at 107,000 in FY 2008. NCA continues to strive to meet its accessibility goal of 90 percent of all veterans living within 75 miles of open national or State veterans' cemetery.

The Veterans' Millennium Health Care and Benefits Act (P.L. 106-117) required NCA to establish six new National Cemeteries. Fort Sill opened in 2001 under the fast-track program, while the remaining five, Atlanta, Detroit, South Florida, Pittsburgh, and Sacramento are in various stages of completion.

Maintaining cemeteries as national shrines is one of NCA's top priorities. This commitment involves renovating gravesites by raising, realigning and cleaning headstones and markers. The work that has been done so far has been outstanding, however, adequate funding is key to maintaining this very important commitment. The American Legion recommends $150 million for the National Cemetery Administration in Fiscal Year 2004.

STATE CEMETERY GRANTS PROGRAM

The State Veterans Cemetery Grant Program continues to be a very popular and much needed program administered by VA. This program was designed to assist States in providing gravesites for veterans where NCA is unable to do so. This program is not intended to replace National Cemeteries, but to complement them. Grants for State-owned and operated cemeteries can be used to establish, expand and improve on existing cemeteries.

Under this program cemeteries must conform to the standards and guidelines prescribed by VA with regards to site selection, planning and construction. Like the NCA, these State cemeteries must be operated solely for the burial of service members who die on active duty, veterans, and their eligible spouses and dependent children.

The State Cemeteries accommodated over 15,000 burials in FY 2001. In light of the aging veteran population and with deaths expected to peak at 687,000 in 2006, it is necessary that this program remain viable. Now is the time to ensure that funding is commensurate with the mission of the program. The American Legion recommends $37 million for the State Cemetery Grants Program in Fiscal Year 2004.

VETERANS BENEFITS ADMINISTRATION

The American Legion is gravely concerned by the proposed straight line staffing request for the Veterans Benefits Administration's (VBA) Compensation and Pension Service and for the Board of Veterans Appeals. There are long-term workload demands associated with the current backlog of pending claims that will extend well into FY 2004. VBA acknowledges there will also be a continued influx of new and reopened claims, based on the enactment of expanded benefit entitlements by the 107th Congress, including the Combat Related Special Compensation Pay Program, an expectation of additional presumptive diseases, and recent precedent decisions of the courts. Despite the fact that the present military build-up has been underway for a number of months, the budget request does not take into account the involvement of thousands of additional active duty personnel. VA must be able to provide these men and women timely, quality service upon their return to civilian life as veterans, in addition to its ongoing responsibility to current veterans.

Despite assertions of improved quality decision-making, the number of appeals being filed continues to increase as does the number of appeals requiring further development either by the regional offices or the Board of Veterans Appeals. The American Legion believes these organizations will require additional personnel, if they are to achieve the ambitious service improvement goals promised the Nation's veterans and their families in this budget request.

VETERANS BENEFITS ADMINISTRATION LEGISLATIVE INITIATIVES

VBA's net mandatory funding request reflects the enactment of several legislative proposals. These include:

• A 2-percent COLA in compensation benefits. The American Legion supports an annual cost-of-living adjustment in disability compensation and DIC benefits.

• Legislation to overturn the decision of U.S. Court of Appeals for the Federal Circuit in *Allen* v. *Principi*, which held that VA must pay compensation for alcohol or drug-abuse disabilities, if they are secondary to a service-connected disability. The American Legion is opposed to any effort to eliminate or restrict a veteran's right to compensation for any disability or disabilities that are determined to be secondary to or a manifestation of the service connected disability. VA is responsible for administering the law not making moral judgment concerning what is or is not misconduct, as it did with the issue of tobacco-related illnesses. Such legislation would be an effort to punish certain disabled veterans for their service-related problems.

• Legislation to pay the full rate of compensation to certain Filipino veterans and their survivors. The American Legion continues to support this change in the law to recognize the military service performed by these veterans during World War II.

• Legislation to extend the operations of the Manila VA Regional Office for an additional five years. The American Legion favors the VA's continued presence in the Philippines, in order to provide timely service to these veterans and their families.

• Amend the law to extend the time limit for education benefits for members of the National Guard. Because the National Guard is now such an integral part of the armed forces, The American Legion believes this will be a much needed change in the law.

• Amendment of the Montgomery GI Bill to provide for on-the-job training for certain self-employment training programs. This will assist veterans in taking advantage of additional training through self-employment training programs.

• Legislation authorizing the extension of the Education Advisory Committee. This committee provides valuable input to VA officials.

• Terminate the Education Loan Program. If this program were, in fact, not being utilized as it was originally intended, The American Legion would not object to its termination.

• Convert the Homeless Veterans Guaranteed Transitional House Loan Program to grant program. The American Legion has been a strong supporter of the Homeless Veteran Transitional Housing Program. The American Legion would have no objection to making it into a grant rather than a loan guaranty program.

• Elimination of the 45-day rule for Death Pension. The American Legion has sought the elimination of this restriction, since enactment of OBRA 90.

• Authorize entitlement to government grave marker or headstone for a veteran's marked or unmarked grave, effective from November 1, 1990. This will enable the families of thousands of deceased veterans to obtain a government marker or headstone to reflect their honorable service to the Nation.

• Authorize the payment of the burial plot allowance to State veterans' cemeteries. The American Legion has long favored this additional support for the State Veterans Cemetery Program.

Under the new budget format, the request for VBA provides for a total of $33.7 billion in mandatory funding for compensation, pension, education, vocational rehabilitation, and other benefit entitlements. Within this total, $26.3 billion will be required for the compensation program, $3.3 billion for the pension program, $1.9 billion for education, and $2.4 billion for the other veterans benefit programs. This represents an overall increase of $9.8 billion, over FY 2003. Compensation benefits will increase by $1.8 billion reflecting the proposed 2-percent COLA, additional benefit payments as a result of *Allen* v. *Principi*, an increase in diabetes cases, and increases in the net caseload and benefit payments.

Discretionary funding for VBA's nine business lines totals $1.2 billion. While it provides for an additional 17 FTE for the Education Program, which is much needed, The American Legion is deeply disturbed by the lack of any increase in staffing for compensation program. We believe this will constrain VBA's ability to address the many internal and external challenges emerging in FY 2003, which will have profound budgetary and operational implications for the FY 2004 budget.

Given the many and varied issues that VBA is faced with, it is imperative that Congress critically evaluate the level of discretionary funding requested and whether this will enable the regional offices to operate efficiently and provide timely, quality service that this Nation's veterans expect and deserve. Individuals currently on active duty must also be assured that VA will not only be ready and willing to assist them, but have physical capacity to provide them the timely, quality service they too expect and deserve, without compromising current operations or benefits programs.

VBA is continuing with the implementation of its long-term strategic plan to hire and train a new cadre of adjudicators under its succession plan, continue the computer modernization program, and institute a variety of procedural and programmatic changes intended to improve the claims adjudication process. However, external forces, such as the enactment of legislation providing new benefits and medical care services, and precedent decisions of the courts continue to play a major role in changing VBA's plans, policies, and operations.

Over the course of FY 2002 and FY 2003, VBA has been able to make substantial progress toward realizing Secretary Principi's goal of a pending case backlog of 250,000 cases with an average processing time of 100 days by the end of September 2003. In March 2002, the regional office backlog peaked with over 423,000 pending cases requiring rating action. Some 40 percent of these cases were over six months old. There were also 147,000 cases requiring some other type of action. Only 12 percent were six months or older. In addition, there were approximately 107,000 cases in appellate status. Of these, over 20 percent were cases that had been remanded by the Board of Veterans Appeals for further required development and readjudication. In human terms, there were over 670,000 claimants waiting and waiting for action on their case. Those with remanded appeals would have been waiting two to three years or longer.

According to VA data, by January 2003, the number of cases awaiting rating action had been reduced to 330,300 with only 32 percent older than six months and the number of cases requiring some other type of action was down to 81,500 but over 28 percent were older than six months. However, the number of cases in appellate status had grown to over 122,000. These statistics give a false impression of improvement. The drop in the claims backlog has been achieved largely at the expense of those whose claims were on appeal at the regional offices. VBA's efforts and resources were focused almost exclusively on pending claims, while appeals, including remands, were virtually ignored, since there was no work credit toward the station's production goals. In response to The American Legion's criticism concerning the lack of action on appeals and the hardship this imposed on disabled veterans, regional offices have, within the last several months, begun to address their appellate workload and pending remands, in particular.

The backlog of claims and appeals are, in our view, a symptom of unresolved systemic problems that have for years adversely affected the claims adjudication and appeals process. These problems include frequent decision-making errors, lack of compliance with the VCAA's notice and development requirements, the absence of personal accountability, ineffective quality control and quality assurance, and inadequate training. The current work measurement system does not provide reliable, accurate data upon which to assess VBA's real resource needs. VBA is faced with a serious dilemma. While endeavoring to address these thorny quality-related issues, the regional offices are, at the same time, aggressively trying to process claims faster. From the results, it appears they still have not found a way to successfully balance these competing priorities. The American Legion remains concerned by the effects of VBA's emphasis on production rather than quality decision-making, i.e., ensuring full and complete development with a decision that is fair and

proper—the first time. This results in cases continuing to churn through the system, for the sake of an artificial goal.

The straight line staffing level requested for FY 2004 is based on the assumption that, with the realization of the Secretary's backlog reduction goal, VBA would be able to more effectively address the many quality-related problems as well other long-outstanding issues. Given past performance, The American Legion believes this is an unrealistic strategy and will not afford VBA the flexibility to cope with current workload demands, let alone some unanticipated contingency. As an example, a December 2002 decision by the United States Court of Appeals for the Federal Circuit determined that VA had used the wrong effective date for grants of service connection in Agent Orange-related diabetes claims. To date, action has been completed on over 88,000 Agent Orange-related diabetes claims. Some 17,000 are still pending. Data is not available on the number of cases that will have to be reworked, as a result of this decision. Considering the number of cases involved, this additional workload will be substantial and could significantly alter regional office production timelines and resource requirements. Another example of future workload demand will be VA's role in the Combat Related Special Compensation Pay program.

The American Legion believes that an increase in staffing in the compensation and pension programs for FY 2004 is both prudent and necessary. This reflects the increasingly complex nature of the claims and appeals process, the volume of additional work anticipated in FY 2003-2004, and the ongoing need to rebuild the core adjudication staff to replace the increasing number of experienced decision-makers who are retiring within the next one to two years.

APPEALS

Staffing at the Board of Veterans Appeals in FY 2004 will decrease by 3 FTE from the FY 2003 level to 184 FTE. The proposed reduction in personnel is predicated on the expected lower volume of incoming new appeals and returning remands. However, given the number of appeals currently in the system and regional offices' continuing quality problems, The American Legion is concerned that the Board's new Development Program will require additional support both from the Board and from the C&P Service.

Beginning in February 2002, the BVA was given the authority to further develop appeal cases rather than remanding them to the regional office. The American Legion understands that 15 FTE were assigned to this unit. By the end of FY 2002, of the 17,231 appeals decided, the Board had remanded 3,328 or 19 percent. This figure is somewhat misleading, since, in addition to the regular remands, the Board has undertaken development of over 9,000 cases that would have previously required a remand back to the regional office for further needed development and readjudication. Staffing for this unit is 32 FTE. The goal of the program is to ensure greater attention to full due process and quality decision-making, while providing claimants more timely action on the appeal. However, without a substantial improvement in the quality of regional office decisions, the BVA will have to assume more and more of the regional offices' development and adjudication workload, which will require additional staffing resources.

The American Legion is concerned that regional office's focus on speed and production versus quality and propriety is directly contributing to the growth of the appellate backlog, which now tops 123,000 appeals. Each of these cases represents a veteran or a veteran's family who, after many months of waiting, is very dissatisfied with the decision they received on their claim for disability or death benefits. They will wait many more months before their case gets before the Board. In 2002, the average appeals resolution time was 731 days. This is projected to improve to 590 days in FY 2003 and to 520 days in FY 2004.

As noted earlier, The American Legion remains concerned by the problems arising from the regional offices' general lack of compliance with the duty to notify and duty to assist provisions of the Veterans Claims Assistance Act of 2001. This legislation was one of the most significant, pro-veteran changes in the VA claims adjudication system in the past decade. However, VBA continues to give only lip service to this law. While claimants receive what is termed a "VCAA" letter, it generally lacks essential information about the claim and what evidence is actually needed to grant the benefit sought in the particular case. Such letters are usually long and confusing, nonspecific, and full of bureaucratic language, which may or may not be accurate or appropriate to the claim. Rather than helping the individual with the development of the claim, these letters frequently generate more questions, phone calls, and correspondence to their representative or the regional office. In the end, the type of VCAA letter currently in use serves to delay rather than to facilitate the claims process. They set the stage for an appeal and, ultimately, additional work

for the BVA and frustration and hardship for thousands of veterans and their families.

EDUCATION

The American Legion commends the increased-funding request for educational programs and support staff for the FY 2004 budget. The American Legion deeply appreciates Congress' attempts to provide for a stronger Montgomery GI Bill, (Chapter 30) including an increase in the monthly entitlement rate for active duty members from $900 to $985. However, due to the increased use of Reservists for homeland security and various overseas commitments around the world, there needs to be a significant increase in their monthly entitlement rates that are currently below $300 a month.

The American Legion also acknowledges the proposed increase in benefits to children and spouses of veterans who died of a service-connected disability or whose service-connected total disability is rated permanent, under Chapter 35 of title 38, United States Code. Having a stronger dependent/survivor educational benefit program is necessary to provide the Nation with the caliber of individuals needed in today's all volunteer Armed Forces. Without providing proper incentives, the military of the 21st century will be hard pressed to effectively carry out its mission.

VOCATIONAL REHABILITATION AND EMPLOYMENT

The American Legion is pleased with the funding level requested for the Vocational Rehabilitation and Employment program in FY 2004. The American Legion has always been a strong supporter of the services this program provides eligible service-disabled veterans. The training and education assist disabled veterans in becoming employable and helps them obtain and maintain suitable employment. The American Legion is pleased by the emphasis placed on the new Employment Specialist position as a means of redirecting the program toward the veteran's employment. During this time of economic uncertainty, meaningful employment should never be denied to veterans, especially those with a service-connected disabling condition.

Mr. Chairman and Members of the Committee: The American Legion has outlined many issues in our testimony today. We believe all of these issues are important and we are fully committed to working with each of you to ensure that America's veterans receive the entitlements they have earned. Whether it is improved accessibility to health care, timely adjudication of disability claims, improved educational benefits or employment services, each and every aspect of these programs touches veterans from every generation. Together we can ensure that these programs remain productive, viable options for the men and women who have chosen to answer the Nation's call to arms.

Thank you for allowing The American Legion the opportunity to appear before you today.

Chairman SPECTER. Thank you very much, Mr. Wilkerson.

We turn now to Mr. Dennis Cullinan, Director of the National Legislative Services for the Veterans of Foreign Wars. Mr. Cullinan has an undergraduate degree from State University of New York in Buffalo, where he also received his master's degree. He was an electronic technician aboard the USS Intrepid and committed three tours of duty in Vietnamese waters. So you have the real perspective, Mr. Cullinan. The floor is yours.

STATEMENT OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. CULLINAN. Thank you very much, Mr. Chairman. On behalf of the men and women of the Veterans of Foreign Wars, I want to thank you for including us in today's most important hearing. As an organization and as a proud co-author of The Independent Budget, we will focus on the construction portion of the budget here today.

It is clear that if VA does not invest proper amounts of money in its infrastructure, patient comfort, safety, and VA's ability to

modernize equipment and facilities will be compromised. Supporting additional funding now will lessen future burdens on patients and staffs, improve patient and worker safety, make health care delivery simpler, and even reduce costs in the long term.

Despite the importance of those factors, we are once again left with a budget that falls far short of these important goals. The Administration request of $272 million and $252 million for major and minor construction projects, respectively, is far too low. It falls far below our recommended levels of $436 million and $425 million for such projects.

Further, VA's request for major and minor construction includes funding for Capital Assets Realignment for Enhanced Services, the CARES process, something that we believe should be kept separate. Deducting the $183 million that is targeted for CARES leaves a paltry $89.3 million for major construction projects.

The pending status of CARES has led to the deferral of many basic projects vital to the maintenance of VA's physical plant. The CARES process should not distract from VA's obligation to protect its health care assets. We are greatly concerned with the way VA has delayed major construction projects because of CARES.

With respect to the CARES process as a whole, we generally remain supportive. We acknowledge that there are some VA facilities that are unusable or unnecessary due to aging infrastructure as well as the transformation of the system. Even so, we strongly urge VA to exercise great care in divesting itself of properties until the process is complete.

If the process does truly enhance services, then we are fully behind it. VA must ensure that the statistical model used reflects the particulars of VA's many specialized treatments to ensure that CARES really does serve the veteran population both now and into the future.

VA must also ensure that veterans, VA's patients and customers, have a voice in this process. All concerned parties must know what is going on and what the planning process is so that we can make informed decisions and suggestions.

One final point, we urge the Congress to enact legislation to raise the limit on minor construction projects to $10 million. The current cap inhibits many VA facilities from properly carrying out construction projects.

Mr. Chairman, this concludes my testimony. I thank you.

[The prepared statement of Mr. Cullinan follows:]

THE PREPARED STATEMENT OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. Chairman and Members of the Committee: On behalf of the 2.6 million men and women of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I wish to thank you for including us in today's important hearing.

As an organization, and as a proud coauthor of the Independent Budget (IB), we are strong advocates for an adequate budget for the Department of Veterans Affairs (VA). While the primary focus of that attention is on the actual delivery of health care and benefits for our Nation's veterans, we cannot afford to forget the importance that construction and maintenance play in the process. If VA does not invest proper amounts of money in its infrastructure, it will have immense repercussions in the coming years when patient comfort, safety and VA's ability to modernize equipment and facilities are compromised. Supporting additional funding now will lessen future burdens on patients and staffs, improve patient and worker safety, make health care delivery simpler, and even reduce costs in the end.

Despite the importance of those factors, we are once again left with a construction budget request that falls short of these important goals. Using the traditional budget methodology, the Administration request calls for $272.7 million and $252.1 million for major and minor construction projects respectively. This is far short of the $436 million and $425 million the IB recommends for major and minor construction projects. Further, VA's request for major and minor construction incorporates funding for the Capital Assets Realignment for Enhanced Services (CARES) process; something we believe should be kept separate. Besides the $183 million earmarked for the CARES, VA is requesting a paltry $89.3 million for major construction projects. Our recommendation of $436 million does not include these CARES projects. When one considers the CARES numbers separately, the construction accounts are even more strikingly deficient.

The Veterans Health Administration (VHA) is charged with maintaining over 2,026 buildings, which includes 162 hospitals, 675 outpatient clinics and 137 Nursing Homes, with almost half of them over fifty years old. It is essential that VA repair and enhance this vital, but aging, infrastructure to delay the erosion of the initial capital investment. As in past years, we cite an independent study of VA's facilities conducted by Price Waterhouse. Their study indicated that VA should allocate between 2 and 4 percent of their asset value into maintenance and an additional 2 to 4 percent for improvements. Again, the budget is not sufficient to meet these needs. VA should spend over $700 million annually on upkeep alone.

This insufficient request taken together with years of under-funding will create an even lengthier backlog of nonrecurring maintenance issues that must be addressed before VA's aged properties deteriorate further. This backlog includes the 890 buildings deemed at "significant risk" and the 73 buildings considered an "exceptionally high risk" of catastrophic collapse or major damage because of seismic deficiencies. The IB believes that VA needs $285 million to begin the correction of these seismic deficiencies while the FY '04 budget provides less then 10 percent of that amount, $20 million. We also believe that VA should have an additional $400 million for the reduction in backlog of nonrecurring maintenance issues. VA must focus on these problems before patient safety and access become a larger crisis.

We recognize the difficulty of VA's position with regard to the construction budget. VA must often carry out these backlogged maintenances and improvements within the context of the larger CARES process. Despite this, just as we strongly urge VA exercise restraint in divesting itself of properties until the process is complete, we also point out that it is essential that construction and repair continue on existing facilities. The pending status of CARES has led to the deferral of many basic projects vital to the maintenance of VA's physical plant. VA has identified a number of high-risk buildings in desperate need of repair, and the CARES process should not distract from VA's obligation to protect its assets, whether they are to be used in their current capacity or to be realigned.

With respect to the CARES process, as a whole, we generally remain supportive. We acknowledge that there are some VA facilities that are unusable or unnecessary due to the aging infrastructure as well as the transformation of VA health care into a more outpatient-focused system. If the process truly does enhance services, then we are fully behind it. Unfortunately, the results from Phase I, the pilot project in Veterans Integrated Service Network (VISN) 12, are so far inconclusive.

We remain concerned that the actuarial service VA used for projections during planning may not have the proper data. VA has many specialized programs for illnesses and diseases unique or particularly problematic for an aging veterans' population. The specialized care provided for chronic mental illness, spinal cord injuries, post-traumatic stress disorder, and other similar illnesses would not be accurately reflected in statistical data based on outside medial facilities. VA must ensure that the statistical model used reflects the particulars of VA's many specialized treatments to ensure that CARES really does serve the veterans population both now and in the future.

Another concern, that was particularly problematic in Phase I, is the lack of clear communication. As Phase II begins, and rapidly expands the process throughout the country, we must ensure that veterans—VA's patients and customers—have a voice in the process. We simply must know what is going on, and what the planning process is so we can make informed decisions and suggestions.

Perhaps our greatest misgiving is with the way that VA has delayed major construction projects because of the CARES process. As expressed previously, VA absolutely must continue maintenance and upgrades to existing facilities for the health of the infrastructure. If it is clear that CARES will not affect a particular hospital or facility, it is essential that VA begins, and Congress appropriates the money for, the major construction projects many of these facilities desperately need. We are optimistic that the $225 million contained in the request for CARES is a sign that

VA recognizes the complications that delaying important construction would create. However, the IB recommends $1 billion as a down payment toward immediate construction needs under the CARES process. Further, we urge VA and Congress to work together in future years to ensure a proper and steady stream of funding to begin construction on projects as they are identified by the CARES process to avoid losing as much time as possible.

On a final note, we would also request a fundamental change to the way major and minor construction projects are designated, which would greatly enhance VA's ability to solve problems and deficiencies. We urge the Congress to enact legislation that would raise the limit on minor construction projects from $4 million to $10 million. This cap inhibits many VA facilities from properly carrying out construction projects by forcing them to reduce the scope of the project or to group several small projects in an uneconomical, piecemeal approach. Raising this cap would allow VA to conduct more essential projects in an efficient and safe manner that would greatly lessen the burden and inconvenience on patients and staff.

VA simply must do a better job protecting and investing in its capital infrastructure. If basic care is not provided, the physical health of the system will continue to deteriorate. Addressing these issues in a timely manner and with proper planning will be of great benefit. If these issues are not addressed, it will only serve to increase the burden on patients and staff and be a detriment to patient safety and VA's ability to deliver health care long into the future. We strongly urge that Congress take steps to correct this inadequate construction request and to support the funding levels and suggestions we have brought before you today.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or the Committee may have.

Chairman SPECTER. Thank you very much, Mr. Cullinan.

Our next witness is Mr. Carl Blake, Associate Legislative Director for the Paralyzed Veterans of America. He graduated from the U.S. Military Academy at West Point, where he received his bachelor's degree in May of 1988, and was commissioned as a second lieutenant in the United States Army.

When I read about you being a second lieutenant, Mr. Blake, I think about my having been a second lieutenant. I did not do anything as prestigious as attending West Point, but I was an ROTC graduate at the University of Pennsylvania and served for 2 years during the Korean War stateside.

We had summer training camp for 6 weeks at Lowry Air Force Base. We got there on June 25, 1950. I am sure everybody remembers June 25, 1950. That was the day the Korean War started.

And 2,000 students between their junior and senior years turned into Lowry Air Force Base and got our khakis and our M1s, and we were sure we were on our way to Korea. But after they had us for 6 weeks, they sent us back to school. They decided they wanted to win the war.

[Laughter.]

And on graduation, I got my commission and served and found it to be a great experience. I think that military service is a very positive thing, developmentally for young people to undertake. It gives you a little more appreciation for what goes on in the world—although I did not see combat and did not serve overseas. It gives you a little better appreciation when you have to vote on a resolution for the use of armed force.

Well, that uses up most of your time, Mr. Blake.

[Laughter.]

Mr. BLAKE. Thank you, Mr. Chairman. I will take any questions you have.

[Laughter.]

Chairman SPECTER. Thank you for joining us, and we will start the clock at the beginning.

STATEMENT OF CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Mr. Chairman.

I am pleased to present the health care portion of The Independent Budget for the fiscal year 2004. When VA's fiscal year 2004 budget for health care became public several weeks ago, they touted it as a historic increase of $1.9 billion. Now that we have had the opportunity to dig into the details of this proposed budget and have a good understanding of what makes up that historic increase, we know that it will simply not provide adequate funding for the needs of our veterans.

Unfortunately, most veterans needing health care will gain their first perspective of this budget not from digging into the details, but from digging into their pockets when they are forced to pay for needed care.

It is clear to us that the Administration's budget relies heavily on management efficiencies and collections from others, especially veterans, and not enough on appropriated dollars.

The Independent Budget has proposed $27.2 billion in real appropriated dollars for VA health care. These are funds needed to address a variety of matters that are expressed in detail in the full "Independent Budget" document.

Long-term care for veterans will need more than enrollment fees and increased co-payments to address the needs of our aging veteran population. Care at home is very important. But so is extended care in VA facilities.

Ironically, the proposed enrollment fees and increases in co-payments may swell the proposed budget, but it will also chase away many of the veterans who so dearly need the system and, in many cases, rely heavily on that system. Indeed, this is what the VA is hoping for and planning on.

For many who need VA's specialized services, VA health care is not only the best game in town, it is the only game in town. Many older veterans, retired and on fixed incomes, have sought VA health care because of the rising costs of other public and private health insurance and care plans. The VA has become their safety net.

The members and endorsers of The Independent Budget strongly encourage you not to let the VA price itself out of their reach.

The Administration has proposed $408 million for research. We are hopeful that your committee will accept the $460 million, the continuity and strength of which the VA research is a national resource and critical.

The lack of consistent funding for VA, along with the uncertainty attached to the process, fuels efforts to deny more veterans health care. Mandatory funding legislation can be designed to ensure that VA has sufficient resources to meet existing statutory obligations. By including veterans currently eligible and enrolled for care, we will protect the system and the specialized programs VA has developed over the years.

And finally, Mr. Chairman, speaking for PVA, we don't want any new members. But as our Nation continues to prepare for war, let our Congress and the Administration make certain that VA's

health care system will be strong and well prepared for a new generation of veterans to come.

This concludes my testimony, and I would be happy to answer any questions.

[The prepared statement of Mr. Blake follows:]

THE PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. Chairman and members of the Committee, as one of the four veterans services organizations publishing The Independent Budget, Paralyzed Veterans of America (PVA) is pleased to present our views on the state of funding for the Department of Veterans Affairs (VA) health care system and the Administration's FY 2004 budget request.

I am Carl Blake, Associate Legislative Director of the PVA. PVA is the only national veterans' service organization chartered by Congress to represent and advocate on behalf of our members and all Americans with spinal cord injury or disease. All of PVA's members, in each of the fifty States and Puerto Rico, are veterans with spinal cord injury or dysfunction.

This is the seventeenth year, PVA, along with AMVETS, Disabled American Veterans and Veterans of Foreign Wars have presented The Independent Budget, a policy and budget document that represents the true funding needs of the Department of Veterans Affairs. The Independent Budget uses commonly accepted estimates of inflation, health care costs and health care demand to reach its recommended levels. This year the document is endorsed by 45 veterans service organizations, and medical and health care advocacy groups.

Mr. Chairman, we are deeply troubled by the Administration's budget request for VA health care programs. It does not come close to meeting the projected needs of the veterans seeking VA health care next year. For nearly five months, the VA was forced to operate under the severely constrained funding levels of FY 2002, putting enormous pressure on a health care system nearing critical condition due to budgetary shortfalls.

Health care demand is rising; the cost of that care is soaring as well. In reaction, the Secretary of Veterans Affairs has taken the unprecedented step of stopping enrollment of Category 8 veterans. Despite touted increases in the FY 2004 request, the Administration proposes even more draconian steps to curtail access. The proposed budgetary increases rely too heavily on increased collections from new co-payments for services and prescription drugs and a new proposed enrollment fee imposed on Category 7 and 8 veterans. Any proposed additional increase derived by unspecified "management efficiencies" disappears completely with VA admitting just recently that it is currently running at a $1.9 billion deficit this year.

We have reworked the Administration's numbers from their unusual presentation this year to be able to make appropriate comparison with The Independent Budget recommendation in the customary way the budget and appropriations bills are usually presented. We have included with this testimony two charts that we have prepared that delineate these accounts and compare The Independent Budget's figures with those of the Administration. We have also included a chart prepared by the VA that displays its FY 2004 request in the traditional manner. As is the custom with Independent Budget recommendations, we have also removed the collections from the Medical Care line to indicate the true amount of federal appropriations needed to fund medical care next year. The Independent Budget Veterans Service Organizations strongly believe that veterans' health care is a federal obligation. Increasing collections from veterans or their health care insurers only allows budgeters to offset federal dollars that are needed.

Once these recalculations have been done, the Administration is requesting $25.2 billion for VA health care. The Independent Budget is recommending $27.2, or two billion more than the Administration would allow. With the FY 2003 medical care appropriation set at $23.9 billion, the budget request would provide only $1.3 billion this year over that level.

The Administration is proposing implementing an annual enrollment fee of $250 for all currently enrolled Category 7 and 8 veterans. It is also proposing more than doubling the prescription fee to $15 and raising the cost of each outpatient visit to $20. These punitive co-payments are designed as much to swell the projected budget increase as they are, the VA admits, to deter veterans from seeking their care at VA medical facilities. The VA estimates that the end result of its proposals will decrease the number of Category 7 and 8 veterans by 378,818, or nearly 34 percent.

The cost of these co-payments is designed to have that effect on people who might want to seek care at VA. Imagine the effect of these additional costs on those who have no other choice but to get care at VA.

Mr. Chairman, The Independent Budget makes a strong statement in opposition to co-payments. From PVA's standpoint, we can make an additional case in further opposition. The Congress gave the Secretary of Veterans Affairs the authority to set and raise fees. What was once thought of as only an administrative function has now become, in times of tight budgets, an easy way to try and find the dollars to fund health care for veterans. When appropriations are in short supply and demand for health care is high, co-payments have become the new way to fund the VA out of the pockets of the veteran patient. The VA has stated that their objective in curtailing access to the so-called "higher income" veterans in Categories 7 and 8 is to focus their resources on the core mission of the VA, the service-connected, the poor and those in need of specialized services. Certainly PVA can appreciate that goal as our members, veterans with spinal cord injury and dysfunction, fall within those categories of veterans with special needs seeking care at VA spinal cord injury centers—but at what cost?

Our first concern rests on the fact that those increased co-payments collected from Category 7 and 8 veterans are being used to pay for the treatment of Category 1 through Category 6 veterans. It is completely antithetical to PVA's view, for instance, to have one veteran in Category 8 paying for the care of a 100 percent service-connected disabled veteran in Category 1. The cost of that care is a federal duty and a federal responsibility.

Second, Committee members should not embrace the generalization that just because Category 8 veterans are considered "higher income" these co-payments do not impose an undue burden on their ability to pay. There are few, if any, millionaires seeking VA health care in this category. For Category 7s, starting at income levels of $24,000, even with the geographic cost-of-living in the HUD index, these veterans, for the most part, are hardly wealthy. For many of them, particularly those who are older, retired, and on fixed incomes, these co-payment increases could be devastating. Many of these veterans have sought VA health care because of the rising costs of other public and private health care plans and insurance. The VA has become their safety net. Sadly VA is following the private sector's lead and pricing itself out of their reach.

Because of their designation as "catastrophically disabled" nearly all PVA members can enroll in the system in Category 4. This, however, does not exempt all of them from the burden these co-payment increases would impose. Those PVA members with non service-connected disabilities, who, because of their incomes could be classified as Category 7 or 8, can be enrolled in Category 4 but are still subject to Category 7 or 8 co-payments. PVA members go to the VA because there is no other system in the country that provides the level and quality of spinal cord injury care. Over 80 percent of our members use the VA for all or part of their care. Because of the nature of their disabilities they require a host of pharmaceuticals, equipment, devices and supplies to function on a daily basis. On average, the imposition of these punitive co-payment increases would bring their total out-of-pocket cost to hundreds of dollars each month. An alternative for many would be to forego outpatient visits or re-filling prescriptions and risk endangering their health and enduring expensive inpatient care.

In other areas of health care, the Independent Budget is pleased that the Administration requested an increase in medical and prosthetic research. Still, its request at $408 million is $52 million below The Independent Budget recommendation of $460 million needed to fund this important and vital program.

In closing, the VA health care system faces two chronic problems. The first is under-funding, which I have already outlined. The second is a lack of consistent funding.

The budget and appropriations process this year is a textbook example of how the VA labors under the uncertainty of not only how much money it is going to get, but, equally as important, when it is going to get it. No Secretary of Veterans Affairs, no VA hospital director, and no doctor running an outpatient clinic knows how to plan and even provide care on a daily basis without the knowledge that the dollars needed to operate those programs are going to be available when they needs them.

Last year's funding was insufficient. The Secretary said early last year that he required a supplemental of $400 million to meet anticipated demand. The supplemental bill was not addressed until nearly the end of the fiscal year. But the White House only obligated $142 million of that amount. The VA was then forced to struggle along, from stop-gap funding measure to stop-gap funding measure, based upon these demonstratively inadequate funding levels. This breakdown in the budget process has had a real and immediate impact on the lives of veterans. Over 230,000

are waiting six months or longer for doctors appointments. Health care delayed is health care denied. If the health care system cannot get the funds it needs when it needs those funds the resulting situation only fuels efforts to deny more veterans health care and charge veterans even more for the health care they receive.

The only solution we can see is for this Committee, and this Congress, to approve legislation removing VA health care from the discretionary side of the budget process and making annual VA budgets mandatory. The health care system can only operate properly when it knows how much it is going to get and when it is going to get it.

We look forward to the assistance of this Committee in making this proposal a reality.

This concludes my testimony. I will be happy to answer any questions you may have.

ATTACHMENT—VA ACCOUNTS 2003 AND FY 2004 REQUEST PRIOR STRUCTURE COMPARED TO FY 2003 APPROPRIATIONS

VA ACCOUNTS-February 13, 2003

[In Thousands]

	FY 2003 *	FY 2004 Request	FY 2004 IB	Difference 2004 & 2003	Difference IB & 2003	Difference IB & 2004
Medical Care	23,889,304	25,218,080	27,201,408	+1,328,776	+3,312,104	+1,983,328
Medical Research	397,400	408,000	460,000	+10,600	+62,600	+52,000
MAMOE	74,230	79,146	84,000	+4,916	+9,770	+4,854
GOE	1,245,849	1,283,272	1,545,000	+37,423	+299,151	+261,728
Inspector General	57,623	61,750	61,000	+4,127	+3,377	-750
National Cemetery	132,284	144,203	162,000	+11,919	+29,716	+17,797
Construction, Major	99,128	272,690	436,000	+173,562	+336,872	+163,310
Construction, Minor	224,531	252,144	440,000	+27,613	+215,469	+187,856
Grants, State Homes	99,350	102,100	150,000	+2,750	+50,650	+47,900
Grants, State Cemeteries	31,792	32,000	37,000	+208	+5,208	+5,000

N.B. Amounts for the Administration's request are displayed in accordance with the traditional account structure.
MAMOE—Medical Administration and Miscellaneous Operating Expenses
GOE—General operating Expenses (Veterans Benefits Administration and General Administration)
* FY2003 amounts include mandated .65 percent rescission. Medical Care was exempted from this rescission.

FY 2004 Request Prior Structure Compared to FY 2003 Appropriations

Prepared by Office of Budget (041C/D)		FY 2002 Enacted 1/ Level	President's 2003 Budget Request 2/	House Level 1/8/2003 3/	Senate (Excludes 2.9% Rescission) 1/23/2003 3/	President's 2004 Budget Request Prior Structure	FY 2004 Compared to President's 2003 Request	FY 2004 Compared to House Level	FY 2004 Compared to Senate Level
		Amount	Amount	Amount	Amount	Amount	Amount	Amount	Amount
Benefit Programs									
Compensation & Pensions	M	$26,044,288	$28,949,000	$28,949,000	$28,949,000	$29,845,127	$896,127	$896,127	$896,127
Readjustment Benefits	M	2,135,000	2,264,808	2,264,808	2,264,808	2,529,734	264,926	264,926	264,926
Veterans Insurance & Indemnities	M	26,200	27,530	27,530	27,530	29,017	1,487	1,487	1,487
Veterans Housing Benefit Program Fund									
Program	M	203,278	437,522	437,522	437,522	305,834	-131,688	-131,688	-131,688
Administrative	D	164,497	168,207	168,207	168,207	154,850	-13,357	-13,357	-13,357
Native American Veterans Housing Program	D	544	558	558	558	571	13	13	13
Education Loan Program									
Program	D	1	1	1	1	0	-1	-1	-1
Administrative	D	64	70	70	70	0	-70	-70	-70
Vocational Rehabilitation Loan Program									
Program	D	72	55	55	55	52	-3	-3	-3
Administrative	D	274	289	289	289	300	11	11	11
Total Benefit Programs		28,574,218	31,848,040	31,848,040	31,848,040	32,865,485	1,017,445	1,017,445	1,017,445
Medical Programs									
Medical Care	D	21,473,164	22,743,761	23,889,304	23,889,304	25,218,080	2,474,319	1,328,776	1,328,776
MCCF	D	1,133,214	1,448,874	1,576,061 4/	1,576,061	2,100,000	651,126	523,939	523,939
Total Medical Care	D	22,606,378	24,192,635	25,465,365	25,465,365	27,318,080	3,125,445	1,852,715	1,852,715
Medical & Prosthetic Research	D	371,000	394,373	405,000	400,000	408,000	13,627	3,000	8,000
MAMOE	D	66,731	69,716	74,716	69,716	79,146	9,430	4,430	9,430
Total Medical Programs		23,044,109	24,656,724	25,945,081	25,935,081	27,805,226	3,148,502	1,860,145	1,870,145
Construction Programs:									
Construction, Major	D	183,180	193,740	193,740 5/	144,790	272,690	78,950	78,950	127,900
Construction, Minor	D	210,900	210,700	240,700	210,700	252,144	41,444	11,444	41,444
Parking Revolving Fund	D	4,000	0	0	0	0	0	0	0
Grants State Extended Care Facilities	D	100,000	100,000	100,000	100,000	102,100	2,100	2,100	2,100
Grants State Veterans Cemeteries	D	25,000	32,000	32,000	32,000	32,000	0	0	0
Total Construction Programs		523,080	536,440	566,440	487,490	658,934	122,494	92,494	171,444
General Operating Expenses & Misc:									
GOE - VBA	D	955,352	992,000	992,100	992,000	1,004,704	12,704	12,604	12,704
Credit Reform Administrative (non-add)		*160,648*	*164,513*	*164,513*	*164,513*	*150,975*	*-13,538*	*-13,538*	*-13,538*
Total GOE-VBA (non-add)		*1,116,000*	*1,156,513*	*1,156,613*	*1,156,513*	*1,155,679*	*-834*	*-934*	*-834*
GOE - General Administration	D	240,376	264,418	259,318	264,418	278,568	14,150	19,250	14,150
Credit Reform Administrative (non-add)		*4,731*	*4,611*	*4,611*	*4,611*	*4,746*	*135*	*135*	*135*
Total GOE- General Administration(non-add)		*245,107*	*269,029*	*263,929*	*269,029*	*283,314*	*14,285*	*19,385*	*14,285*
General Operating Expenses		1,195,728	1,256,418	1,251,418	1,256,418	1,283,272	26,854	31,854	26,854
National Cemetery Administration	D	121,169	133,149	133,149	133,149	144,203	11,054	11,054	11,054
Inspector General	D	52,308	55,000	61,000	55,000	61,750	6,750	750	6,750
Total GOE & Misc.		1,369,205	1,444,567	1,445,567	1,444,567	1,489,225	44,658	43,658	44,658
Total Appropriation		$53,510,612	$58,485,771	$59,805,128	$59,715,178	$62,818,870	$4,333,099	$3,013,742	$3,103,692
Total Discretionary (D)		**$25,101,846**	**$26,806,911**	**$28,126,268**	**$28,036,318**	**$30,109,158**	**$3,302,247**	**$1,982,890**	**$2,072,840**
Total Mandatory (M)		**$28,408,766**	**$31,678,860**	**$31,678,860**	**$31,678,860**	**$32,709,712**	**$1,030,852**	**$1,030,852**	**$1,030,852**

1/ FY 2002 Enacted level as shown in President's Budget without reflecting transfers; includes supplemental funding under P.L. 107-206 for Medical Care and Compensation and Pensions; excludes a

2/ FY 2003 President's Budget as requested excluding CSRS & FEHB legislation.

3/ Senate and House action on FY 2003 excludes CSRS & FEHB legislation; denies the $1,500 deductible for Medical Care; and includes Mid-Session reestimates for Compensation and Pensions.

4/ The MCCF collections for House and Senate reflects VA's latest estimat 4/ For Major Projects, the Senate provides funding for only 2 proposed seismic projects: Palo Alto #2 and San Francisco..

Chairman SPECTER. Thank you very much, Mr. Blake.

We turn now to Mr. Rick Surratt, Deputy National Legislative Director, Disabled American Veterans. Mr. Surratt served in the Army in 1966. In 1967, he was wounded by shell fragments in the thigh during a Vietnam combat field operation while serving in the 101st Airborne Division.

Well, you have been there, Mr. Surratt. You are a disabled American veteran. As you know, I commented earlier in this hearing about the first disabled American veteran I knew who was my father, who was wounded with shrapnel somewhat similar to your situation. Thank you for joining us, and we look forward to your testimony.

STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. SURRATT. Thank you, Mr. Chairman.

Two core veterans' benefits are medical care and disability compensation. Unfortunately, it is in the administration of these two programs that VA has experienced most of its serious problems in recent years. That is not merely a coincidence. It is because the costs of administration of these two programs are funded by discretionary appropriations.

That is where the President's budget typically shortchanges VA. Therefore, we must look to Congress to appropriate more realistic amounts. Congress has reacted to the crisis in compensation claims processing that resulted in part from inadequate budgets by giving the VA more money for employees to process and decide claims. With more adequate resources and reforms, VA seems to be making some progress in attacking that problem.

The crisis in VA's medical care system not only lingers, however, it has become much worse. The reason is simple. VA does not have the necessary resources to treat all veterans who need medical care. As a result, medical care for veterans is unduly delayed or now denied altogether. It is time to act decisively to correct this intolerable problem.

That is why the DAV, The Independent Budget, and other veterans' organizations now urge Congress to enact legislation to remove this part of the VA budget from the uncertainties and the politics of the annual appropriations process and guarantee adequate funding for veterans' medical care in authorizing legislation.

Now let me turn briefly to the other benefit programs. To remain effective, the benefit programs need adjustments for increases in the cost of living, other changed circumstances, or for general improvements. The IB therefore makes several recommendations for improving the benefit programs.

Although not under the jurisdiction of this committee, one of our most important recommendations is legislation to authorize concurrent receipt of military retired pay and disability compensation. Veterans hope to have your support on this issue.

Among the several compelling issues we raise in the IB, another we would ask that you consider as a priority this year is legislation to eliminate the 2-year limitation on payment of accrued benefits. This limitation unfairly deprives survivors of the full benefits due a beneficiary at the time of death.

We have recommended cost-of-living adjustments with provisions for automatic annual adjustments, for the specially adapted housing, and automobile allowances. We have made recommendations to improve veterans' life insurance programs by increasing maximum coverage and lowering premiums to reflect increased life expectancy, and a number of other recommendations to improve the benefit programs.

Mr. Chairman, that concludes my remarks regarding the budget. I want to again take this opportunity to thank you and this committee for the support you have shown us in the past, and I would certainly be happy to answer any questions you have on these issues.

[The prepared statement of Mr. Surratt follows:]

THE PREPARED STATEMENT OF RICK SURRATT, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Chairman and Members of the Committee: Thank you for the opportunity to present the views of the Disabled American Veterans (DAV), one of the four coauthors of The Independent Budget (IB), on the President's fiscal year (FY) 2004 budget request. This hearing is, of course, of prime importance not only because it begins your formal consideration of the resource needs of VA for the budget year, but also because it sets the broader context for your work during this session on many of the legislative and oversight issues you will address concerning veterans' programs.

As an organization dedicated to the welfare of our Nation's disabled veterans, the DAV is particularly interested in maintaining effective benefits and services for veterans and their dependents and survivors. To remain effective, benefits must be delivered in a correct and timely fashion and the programs must be adjusted for increases in the cost of living and other changed circumstances. The DAV therefore joins with AMVETS, the Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW) to present in the IB our assessment of the resource needs for veterans' programs and our recommendations for improving the benefits we provide to veterans and their eligible family members.

The IB represents the collective views of the four organizations, but, to most effectively use our own resources, we divide primary responsibility for the major parts of the VA budget among the four organizations. In turn, each organization focuses its testimony here primarily on that part of the budget for which it has responsibility. Therefore, my testimony will concentrate predominantly on the Benefits Programs, administrative expenses, and Judicial Review in Veterans' Benefits. Before I address those issues, I do, however, want to discuss one issue of overriding importance to the DAV and all the IB coauthors.

We have many challenges to face this year, but one that is undebatably the most pressing and one that we cannot ignore is the crisis confronting VA's medical care system. The problem may be stated in simple terms: demand for VA medical care exceeds VA's capacity to provide that care to all veterans who need it. With insufficient resources, the system is overwhelmed, veterans are waiting unacceptably long times to be treated, and VA has closed its doors entirely to some sick and disabled veterans. Rather than request the resources VA truly needs, the Administration's proposal in the budget is to drive some of the intended beneficiaries away from the system and, for those not driven to seek medical care elsewhere, shift from the Government to veterans themselves more of the costs of providing care. Rather than seeking increased appropriations, the Administration would squeeze more money from the pockets of veterans needing medical treatment by increasing co-payments and by imposing an annual enrollment fee. In addition to a higher co-payment for a primary care visit, the veteran would be hit with higher co-payments for medications, and could not even be treated until he or she had paid $250 just to get through the door. To treat veterans in that manner is a national disgrace and certainly makes VA's long-time guiding principle, "To care for him who shall have borne the battle. . . " an hypocrisy and a hollow promise. At the same time, the Administration is pressing for another round of tax cuts, which will further reduce revenues and perhaps result in even more draconian proposals to degrade the benefits the citizens of our grateful Nation intended to be provided to veterans as repayment for their extraordinary contributions and sacrifices.

The DAV and the IB urge a different approach. Our approach would be to provide adequate, stable funding for VA medical care under a formula in authorizing legislation that is based on real resource needs rather the capriciousness and uncertainties of the politics of the annual appropriations process. With an adequate and stable funding source, VA could provide timely and quality health care to all eligible veterans and could more effectively conduct long term planning for efficiency and strategic use of its allocated resources.

Already this year, we have two bills in the Senate that would fund veterans' medical care through authorizing legislation. Both S. 19 and S. 50 include provisions for mandatory funding. As with last year, we anticipate a bipartisan bill for this purpose in the House. In addition, this is a solution receiving much attention by the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. We hope to see a strong commitment in the Senate to guarantee funding for veterans' medical care. Now, let me turn to the benefit programs under the Veterans Benefits Administration (VBA).

Under a new budget structure introduced this year, the VA budget requests both mandatory and discretionary funding by each "business line," or each benefit program. The President's budget for all of VBA includes $33.695 billion in mandatory spending and $1.218 billion in discretionary spending. The budget for mandatory spending includes the costs of proposed new legislation, principally $355.2 million to cover a proposed cost-of-living adjustment (COLA) for compensation, which would be based on the increase in the cost of living as measured under the Consumer Price Index (CPI), projected to be 2.0 percent. The compensation COLA applies to disability compensation, dependency and indemnity compensation (DIC), and the clothing allowance.

In addition to the compensation COLA, the President's budget proposes several other legislative changes in the benefit programs, the total cost of which, including the COLA, would be $412.728 million. However, based on projected savings of $127.007 million from a legislative proposal to eliminate compensation for certain service-connected disabilities, the net cost of these changes would be $285.721 million for FY 2004. While we support the compensation COLA and other beneficial legislative proposals, we strongly object to eliminating compensation for certain service-connected disabilities to offset part of the costs of the changes. We oppose taking away benefits from one group of veterans to fund improvements in benefits for other veterans.

The IB also recommends a compensation COLA to maintain the value of compensation in relation to the cost of living. Let me add here, however, that the DAV believes the COLA for disability compensation should be based on the Labor Department's Employment Cost Index (ECI) for private sector wages and salaries. Disability compensation is intended primarily to make up for average impairments in earning capacity in civil occupations, and the ECI would appear to be a more appropriate index for this purpose.

For the compensation program, the Administration proposes legislation to authorize full compensation benefits to New Philippine Scouts and full DIC for eligible survivors of Filipino veterans. This proposal has an equitable purpose, and we do not oppose it.

For the pension program, the President's budget proposes restoration of provisions that would make awards of death pension effective the first day of the month in which death occurred if the claim is filed within 1 year of the date of death. Prior amendments reduced this period from 1 year to 45 days. The IB has no recommendation on this issue, but it would liberalize the program for needy widows of wartime veterans, and in the process, restore uniformity to effective date provisions and thus restore uniformity to the administration of the compensation and pension programs.

The President's budget recommends two legislative changes for education benefits: (1) extension of time for use of education benefits by members of the National Guard, and (2) authorization for on-the-job training in self-employment under the Montgomery GI Bill. We have no objections to these changes. The Administration also recommends elimination of the Education Loan Program because more than 10 years have passed since the last loan was made under the program. We have no position on this recommendation.

For the VA housing program, the budget recommends legislation to convert the direct loan program for Guaranteed Transitional Housing for Homeless Veterans from a mandatory program to a discretionary grant program. The IB has no position on this issue, but we question how the program would be more effective with this change, and we question whether this is simply not a way for the Administration to ultimately reduce a program authorized by Congress to divert the funding to other Administration priorities.

As noted, the President's budget proposes to achieve savings by legislation that would eliminate compensation for certain service-connected disabilities. Specifically, the proposal would eliminate compensation for that part of the impairment from a service-connected disability attributable to alcohol or drug abuse. Except where secondary to another service-connected disability, the law already prohibits compensation for disability from alcohol or drug abuse. For several years, through an erroneous interpretation of law and one that was inconsistent with another interpretation within VA itself, VA denied compensation for disability from alcohol or drug abuse although the abuse was caused by the effects of another service-connected mental or physical disability. Congress intended to prohibit compensation for alcohol and drug abuse as primary conditions, but did not intend to deny compensation when a veteran's service-connected mental or physical disability induced use of alcohol or drugs to escape mental or physical pain. Alcohol use, particularly, is more prevalent among veterans who suffer from the disordered thinking of serious mental conditions or who suffer from the disturbing symptoms of posttraumatic stress disorder caused by severe psychological trauma such as the death and destruction of combat. Having misinterpreted the law against veterans and having that misinterpretation set aside by the United States Court of Appeals for the Federal Circuit, the VA now wants Congress to change the law to conform to VA's improper view of what the law should be. Regrettably, this recommendation reflects very negatively upon the agency that is charged with understanding and having insight into the effects of trauma and severe disabilities upon veterans. It evidences a narrow-minded insensitivity to the real nature of the effects of severe trauma and severe disability upon young men and women who bear these extraordinary burdens and suffer these extremely traumatic experiences. We oppose such an unwarranted, inequitable change in the strongest possible terms, and we urge this Committee to appropriately dismiss this recommendation with no consideration whatsoever.

We are similarly disappointed that the President's budget continues to make so few recommendations to improve veterans' benefits when so many improvements are needed. For the Benefit Programs, the IB makes the following legislative recommendations in addition to its recommendation for compensation COLA:

- To exclude compensation as countable income for Federal programs.
- To repeal the prohibition of service connection for disabilities related to tobacco use.
- To repeal delayed effective dates for payment of increased compensation based on temporary total disability.
- To expand Montgomery GI Bill eligibility to persons who, but for service on or before June 30, 1985, would be eligible for education benefits under this program.
- To authorize refund of contributions to veterans who become ineligible for the Montgomery GI Bill by reason of discharges characterized as "general" or "under honorable conditions."
- To increase the amount of the grants for specially adapted housing and to provide for automatic annual adjustments for increased costs.
- To provide a grant for adaptations to a home that replaces the first specially adapted home.
- To authorize specially adapted housing grants to service members with qualifying service-connected disabilities who are awaiting discharge.
- To authorize payment of reasonable fees for compliance inspections on housing being constructed or adapted under the specially adapted housing program.
- To increase the amount of the automobile grant and to provide for automatic annual adjustments for increased costs.
- To increase the maximum VA home loan guaranty and provide for automatic annual indexing to 90 percent of the Federal Housing Administration-Federal Home Loan Mortgage Corporation loan ceiling.
- To exempt the dividends and proceeds from and cash value of VA life insurance policies from consideration in determining entitlement under other Federal programs.
- To authorize VA to use modem mortality tables instead of 1941 mortality tables to determine life expectancy for purposes of computing premiums for Service-Disabled Veterans' Insurance.
- To increase the maximum protection available under the base policy of Service-Disabled Veterans' Insurance from $10,000 to $50,000.
- To increase the maximum coverage under Veterans' Mortgage Life Insurance from $90,000 to $150,000.
- To repeal the 2-year limitation on payment of accrued benefit.
- To protect veterans' benefits from unwarranted court-ordered awards to third parties in divorce actions.

Though not under the jurisdiction of this Committee, the IB also recommends legislation to remove the offset between military retired pay and disability compensation and legislation to extend the 3-year limitation on recovery of taxes withheld from disability severance pay and military retired pay later determined exempt from taxable income.

Where the President's budget previously separated requests for mandatory funding for the benefit programs from requests for discretionary funding for VBA's General Operating Expenses, as noted, the President's budget this year eliminates that traditional bifurcation, and, in addition, includes in the discretionary funding appropriations for construction. The new format merges the requests for both mandatory and discretionary funding associated with each business line of VBA. The President's request for discretionary funding for all VBA business lines, minus funding for construction, is essentially at the same level as the budget request for FY 2003.

In the business lines under VBA, VA is continuing its several ongoing initiatives to improve the administration of the benefit programs. The most formidable and longest running challenge is the compensation and pension claims backlog. VBA continues to address this problem through a combination of measures, including process changes, improved skills through better training, new technology, and accountability. So many initiatives affecting so many aspects of compensation and pension claims processing are in play simultaneously that the net effect is difficult to appreciate at this time, although we are continually monitoring VA's reported processing times and accuracy rates. New technology plays a major role in the efforts to improve program administration and benefits delivery in the other VBA business lines as well.

This year's budget request would authorize 12,720 total full-time employees (FTE) for VBA, a net reduction of 61 FTE from FY 2003 levels. Compensation and Pension (C&P) Service would maintain FY 2003 levels, which was down 190 FTE from FY 2002. Education Service would gain 17 FTE, while Loan Guaranty Service would lose 73 FTE, Insurance Service would lose 4 FTE, and Vocational Rehabilitation and Employment Service would lose 1 FTE. In this period of change for VBA, the IB has not included recommendations for increased staffing, but we watch with guarded concern for the time being.

In the IB, we have recommended that VBA's program directors be given line authority over their field employees who process and decide benefit claims. Under VBA's current management structure, the C&P Director, for example has no authority to enforce quality standards and VA policy. This presents an obstacle to enforcement of accountability, which is essential to VA's success in overcoming its quality problems.

We have recommended that the Secretary of Veterans Affairs take the steps necessary to improve VA's rulemaking. From our experience over the last several years, we have seen VA's regulations become more self-serving and arbitrary. Veterans' organizations are challenging new VA regulations in court with regularity. Currently, several veterans' organizations have before the United States Court of Appeals for the Federal Circuit a challenge to VA's regulations to implement the legislation that restored VA's duty to assist veterans. If these regulations are invalidated by the court, VA may have to rework a large number of the claims that were developed and decided under the invalidated rules. Additionally, veterans' organizations have before the Federal Circuit a challenge to VA regulations that authorize the Board of Veterans' Appeals (BVA) to obtain new evidence and make initial decisions on issues in claims. This procedure deprives veterans of the statutory right to an initial decision and one review on appeal when they believe the initial decision to be wrong. It creates conditions for increased inefficiency because field office adjudicators can avoid fully developing claims as required by law with the knowledge that BVA will correct record deficiencies on appeal. This shifts the work that should be done in regional offices to VA's appellate board, which was created to "review" field office actions in record development and field office decisions, not develop the record itself and "make" initial decisions on new evidence. Because BVA is now conducting its own record development to correct the deficiencies it identifies in field office development, we are seeing a growing claims backlog at BVA. If the court agrees with our view that VA's regulations authorizing this practice are contrary to law, BVA may well be required to vacate many of its decisions and send the cases back to regional offices to correct record deficiencies and afford veterans the due process required by law. Just last year this Committee reported legislation that was later enacted to override an arbitrary VA regulation on anatomical loss of a breast for compensation purposes. In the IB, we have recommended that Congress scrutinize VA's rulemaking more closely as a part of its oversight role.

Although VBA's C&P Service has many reforms underway to improve compensation and pension claims processing, the IB recommends that the primary focus

should be more on correcting the root causes of the claims backlog. Those who have witnessed C&P's repeated failures to overcome its claims processing deficiencies know that those failures involve repetitive patterns in which VA develops plans but fails to follow through with decisive steps to solve the difficult problems. VA attempts to overcome its serious deficiencies by fine-tuning its procedures and employing new technology. While those efforts may aid in improving claims processing, alone or in combination they are not enough to enable VA to overcome its long-standing problem. The coauthors of the IB believe that it is obvious VA must resolve to focus primarily on eliminating the root causes of its claims backlog if it is to ever succeed in restoring the system to acceptable levels of performance and service. VA's adjudicators make erroneous decisions because they have not been properly trained in the law, they have operated in a culture that tolerated indifference to the law, and they have not been held accountable for poor performance and proficiency. Accordingly, in conjunction with the deployment of better training, VA must take bold steps to change its institutional culture, and it must make its decision-makers and managers truly accountable.

If VA's ambitious goal of improving timeliness takes precedence over its goal of improving quality, VA will merely repeat the failures of the past. Speeding up the process with the single goal of reducing claims processing times and claims backlogs is self-defeating if, because quality is compromised, a substantial portion of the cases must be reworked. In this respect, VA has shown some inability to learn from its past mistakes.

To meet its workload demands, VA must take full advantage of automated information systems. These systems can facilitate case management, claims processing, and decision-making in ways that improve accuracy and efficiency. To determine and implement its optimum performance in record development, disability examinations, and claims disposition, VA is undertaking a review of its claims process with the goal of developing an integrated electronic format to aid in uniform and correct application procedures and substantive rules and to allow for the electronic transmission of data from its source into the claims database. Known as the C&P Evaluation Redesign (CAPER) initiative, this project is being undertaken by a CAPER team, working with outside experts. VA began work on this initiative in 2001 with a goal of nationwide deployment by April 2005. VA now hopes to have this system fully in place by September 2005. To achieve that goal, VA needs approximately $7 million in FY 2004 for business consultants, software/systems integration, independent validation and verification, equipment and software, and employee travel and training. VA needs this funding to stay on its schedule to complete testing of the prototype system it is developing in FY 2003 and have the system fully deployed by September 2005. The IB therefore recommends that Congress provide $7 million for CAPER in the FY 2004 budget. The President's budget requests only $3.8 million. We understand that the President's budget would spend less than our recommendation by completing less of the development in FY 2004.

Inadequate disability examinations have been a major factor in VA's claims processing problems. Experience gained from a pilot project and a contract authorized by Public Law 104 275 demonstrates that a private contractor can economically provide adequate and timely disability examinations to veterans at locations near their homes with a high level of veteran satisfaction. Authority for contract examinations at all VA regional offices would allow VA to improve claims processing nationwide. VA projects that it will request approximately 500,000 disability examinations in FY 2004. To obtain these examinations under contract would require an appropriation of approximately $250 million. The IB recommends that Congress authorize VA to use contractors for disability examinations at all VA regional offices and include $250 million in the budget for contract examinations. The President's budget requests only $50.4 million to continue the current limited use of contractors.

The President's budget request for BVA would essentially maintain the status quo. It requests 448 FTE and $50.443 million in budget authority, a reduction of 3 FTE and an increase of $1.692 million in appropriations. With these resources BVA expects to reduce appeals resolution time (the time from initiation of an appeal to final resolution) from 731 days in FY 2002 and a projected average 590 days in FY 2003 to 520 days in FY 2004. At the same time, BVA projects an increase in BVA cycle time (the time the case is physically at the BVA), from 86 days in FY 2002 and 250 days projected in FY 2003 to 300 days in FY 2004. This increase in the time it takes BVA to resolve its work on the appeal is attributed to BVA's new responsibility to develop evidence in cases where the regional office failed to properly develop the record.

The IB makes only one recommendation for BVA this year. We again recommend that VA amend its regulation that purports to exempt BVA from substantive rules on benefit entitlement that are binding on VA field adjudicators, just as if they were

law. It makes no sense to allow BVA to ignore substantive rules in its decisions that field adjudicators are bound to apply in making claims decisions.

Although not a part of the budget, the DAV objects to new regulations that authorize BVA members to call themselves "Veterans Law Judges." We raise this objection here because allowing Board members to proclaim themselves to be judges will do nothing to benefit decision-making for veterans. While the costs of changing titles in form letters and other materials may not be substantial, there will no doubt be some cost to the taxpayer. That added cost will have no benefit to taxpayers or veterans in return. In addition to the reality that BVA's members are not, in fact, judges, we object because this will unavoidably add unnecessary formality to proceedings Congress intended to remain informal. If Board members desire to have titles that include the word "judge," they will no doubt expect to have the formal demeanor of judges and will expect others to address them and treat them as judges. Congress previously rejected VA efforts to obtain legislation to authorize this change in the title of Board members. Now, VA has issued a rule to authorize Board members to call themselves, and expect others to call them, judges although all pertinent statutes refer to them as "members." We are perplexed by this pretentiousness, which will likely cause others to question the integrity and motives of BVA rather than gain it new respect by reason of this self-declared and artificial change. The DAV recommends legislation to prohibit VA from assigning Board members any title or status other than what is provided in statute.

In addition to the recommendations we make for VA programs, the IB includes recommendations for improving judicial review in veterans' benefits. In enacting legislation in 1988 to authorize veterans to challenge VA decisions in court, Congress recognized the importance of the right to have VA's decisions reviewed by an independent body. Judicial review has had the beneficial effect of exposing administrative departure from the law and forcing reforms within VA. For the most part, judicial review of the claims decisions of VA has lived up to the positive expectations of its proponents. To some extent, it has also brought about some of the adverse consequences seen by its opponents. Based on recommendations in last year's IB, Congress made some important adjustments to correct some of the unintended effect of the judicial review process. We hope to see these changes applied in a manner that will fulfill congressional intent to ensure that veterans have meaningful judicial review in all aspects of their appeals. Other adjustments are still needed, however.

Last year, the IB recommended legislation to change the standard under which the Court of Appeals for Veterans Claims (CAVC or "the Court") reviews VA's findings of fact in claims decisions. The Court's application of the "clearly erroneous" standard has conflicted with and undermined the benefit-of-the-doubt rule. Under the statutory benefit-of-the-doubt rule, VA is mandated to resolve factual questions in the veteran's favor unless the evidence against the veteran is stronger than the evidence for him or her. However, CAVC had been upholding a VA decision when there was any evidence to support it, and this rendered the benefit-of-the-doubt rule unenforceable. Although the legislation eventually enacted did not make the changes recommended by the IB, Congress did amend the law to expressly require CAVC to consider, in its clearly erroneous analysis, whether a finding of fact is consistent with the benefit-of-the-doubt rule. The IB now recommends that the Veterans' Affairs Committees conduct oversight hearings to evaluate whether CAVC is fully carrying out the congressional intent of last year's amendments.

When Congress authorized judicial review of veterans' claims, one of its foremost concerns and intents was preservation of the informality of VA's administrative claims process under conditions in which BVA's decisions would be subject to review by a court. Congress was very much aware of the dangers that the courts might attempt to impose their own formal rules of adversarial proceedings upon VA's informal claims process and therefore sought to prevent this adverse consequence. In imposing its own requirement upon veterans that they must have expressly argued a technical or legal point before BVA to have the point considered by the Court, CAVC has, for its own expedience, largely ignored congressional intent, the law, and the unique nature and purposes of veterans' programs. The Court has done the very thing Congress so carefully and clearly acted to forestall.

Unlike judicial or more formal administrative proceedings where it is the responsibility of the parties to raise and plead all legal arguments and discover and present all material evidence, veterans are not expected to know and plead the legal technicalities of veterans' benefits. Veterans file simple claims forms with basic information, not detailed legal pleadings. Congress repeatedly stated its intent to preserve and maintain this informal process throughout the legislative history of its law to authorize judicial review. It is VA's legal obligation to assist the veteran in filing the claim and developing the evidence, and it is VA's obligation under the law

to consider all relevant legal authorities and potential bases of entitlement regardless of whether they are expressly raised by the veteran. When a veteran appeals to BVA and receives an unfavorable decision, the veteran has exhausted his or her administrative remedies. Any failure to fully develop the record, to fully explore all avenues of entitlement, or to apply all pertinent law is an error of omission by BVA which CAVC should address in its appellate review irrespective of whether the veteran knew of or raised the specific point before BVA. Yet, for its own purposes, CAVC refuses to consider points of argument that were not specifically raised before BVA. By requiring veterans to know and expressly raise and argue all the complex legal points relevant to a claim, CAVC shifts the government's obligations to veterans, imposes unnecessary formalities upon VA's administrative claims process, and fundamentally alters the non-adversarial, pro-veteran nature of VA proceedings. The Court seems unable or unwilling to grasp the simple fact that, in considering veterans' appeals, it reviews a claims record, not a litigation record. The IB therefore recommends legislation to prohibit judicial imposition of formal pleading or so-called "exhaustion" requirements upon the VA claims process.

Currently, VA regulations, with the exception of provisions in the Schedule for Rating Disabilities, are subject to challenge in the Court of Appeals for the Federal Circuit (CAFC). The IB recommends expanding CAFC jurisdiction to permit it to review challenges to the validity of the rating schedule on the narrow basis of whether the rating is contrary to law or is arbitrary and capricious. The coauthors of the IB believe that no unlawful or arbitrary and capricious rating schedule provision should be immune to review and correction.

Because of the advocacy of this Committee, working with the House Veterans' Affairs Committee, we have in past years been able to obtain more reasonable levels of funding for veterans' programs. We have also seen a number of IB recommendations for benefit improvements enacted into law. Obviously, much of what this Committee will seek to accomplish on behalf of veterans this year will be subject to what Congress appropriates for veterans' programs. We urge the Committee to press for a budget that is adequate for existing programs and allows for some improvement in benefits and services for veterans. We hope our independent analysis of the resources necessary for veterans' programs and our legislative and policy recommendations are helpful to you, and we sincerely appreciate the opportunity to present our views and recommendations to the Committee.

Chairman SPECTER. Thank you very much, Mr. Surratt.

Our final witness is Mr. Richard "Rick" Jones, an Army veteran who served as a medical specialist during the Vietnam War era, and who did his undergraduate work at Brown. Mr. Jones has a master's degree in public administration from East Carolina University, and has extensive experience on Capitol Hill, having worked for Senators Coverdell, Faircloth, and East. And he worked in the House as committee staff for Congressmen Hopkins and Stump. I thank you for joining us, Mr. Jones, and we are interested in your testimony.

STATEMENT OF RICHARD JONES, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. JONES. Thank you, sir.

Mr. Chairman, for over 17 years, AMVETS has worked with the Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Indeed, we are proud this year that over 45 veteran, military, and medical service organizations endorse these recommendations.

At the outset, it is important for AMVETS to clearly state that, along with its IB partners, we strongly support shifting VA health care funding from discretionary funding to mandatory. Mandatory funding would give some certainty to health care services. VA fa-

cilities would not have to deal with the whimsy of discretionary funding, which has proven inconsistent and inadequate.

We believe that mandatory funding would provide a comprehensive solution to the current funding problems. Once health care funding matches the actual average cost of care for veterans enrolled in the system with annual indexing for inflation, the VA can fulfill its mission.

I would like members of this committee to know that AMVETS fully appreciates the strong leadership and continuing strong support demonstrated by your committee. AMVETS is truly grateful to those who serve on this important committee. Through your work, you represent the veterans' voice, and you have distinguished yourselves as willing to lead the country in addressing issues important to veterans and their families.

The members of The Independent Budget are encouraged by the Administration's recommended increase in the National Cemetery Administration's resources for fiscal year 2004. However, it should be recognized that while the proposal addresses employment increases and equipment needs, it does not serve to address problems and deficiencies identified in the study on improvements to veterans' cemeteries, a comprehensive report submitted in the year 2002 by VA to the Senate commenting on the conditions of each cemetery.

The members of The Independent Budget recommend that the Senate provide $162 million in fiscal year 2004 for the operational requirements of the National Cemetery Administration, the National Shrine Initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States armed forces.

This is an increase of $17.8 million over the Administration's request for next year. Clearly, the aging veterans population has created great demand on NCA operations. Primarily because of the mortality of World War II and Korean veterans, as well as the rising age of Vietnam War veterans, actuarial projections do not suggest a decline in these demands for many years.

From current interment levels of 89,000 per year, the VA interment rate is projected to increase successively over the next several years, peaking at 109,000 in the year 2008.

For funding the State Cemetery Grants Program, the members of The Independent Budget recommend $37 million for the new fiscal year, an increase of $5 million over the Administration's budget.

Mr. Chairman, I thank you very much for the time you have granted us, and I would be pleased to answer any questions you might have.

[The prepared statement of Mr. Jones follows:]

THE PREPARED STATEMENT OF RICHARD JONES,
NATIONAL LEGISLATIVE DIRECTOR, AMVETS

Mr. Chairman, Ranking Member Graham, and members of the Committee: AMVETS is honored to join fellow veterans' service organizations at this hearing on the VA's budget request for fiscal year 2004. We are pleased to provide you our best estimates on the resources necessary to carry out a responsible budget for the fiscal

year 2004 programs of the Department of Veterans Affairs. AMVETS testifies before you today as a co-author of The Independent Budget.

For over 17 years AMVETS has worked with the Disabled American Veterans, the Paralyzed Veterans of America, and the Veterans of Foreign Wars to produce a working document that sets out our spending recommendations on veterans' programs for the new fiscal year. Indeed, we are proud that over 45 veteran, military, and medical service organizations endorse these recommendations. In whole, these recommendations provide decision-makers with a rational, rigorous, and sound review of the budget required to support authorized programs for our Nation's veterans.

In developing this document, we believe in certain guiding principles. Veterans must not be forced to wait for the benefits promised them. Veterans must be assured of access to high quality health care. Veterans must be guaranteed access to a full continuum of healthcare services, including long-term care. And, veterans must be assured burial in a State or national cemetery in every State.

It is our firm belief that the mission of the VA must continue to include support of our military in times of emergency and war. Just as this support of our military is essential to national security, the focus of the VA medical system must remain centered on specialized care. VA's mission to conduct medical and prosthetics research in areas of veterans' special needs is critical to the integrity of the veterans' healthcare system and to the advancement of American medicine.

In addition, the budget must recognize that VA trains most of the Nation's healthcare workforce. The VA healthcare system is responsible for great advances in medical science, and these advanced benefits all Americans. The VHA is the most cost effective application of federal healthcare dollars, providing benefits and services at 25 percent lower cost than other comparable medical services. In times of national emergency, VA medical services can function as an effective backup to the DoD and FEMA.

Noting the mission of the VA, it is important to understand the areas where VA funding must be increased. The VA budget must address the pending wage increases for VA employees. It must address the enormous backlog in veterans waiting for health care and it must address, as well, VA's large benefits casework backlog. There are severely disabled veterans and those needing home-based healthcare in those backlogs, and I think we can all agree that this situation should be addressed and corrected.

As we look to fiscal year 2004, it is amazing that nearly halfway through the current fiscal year, VA's funding remains uncertain for the remainder of FY 03. We watch a live lesson about the challenges inherent to inadequate funding. Due to a lack of resources, VA took action on January 17 to ban healthcare access to 164,000 veterans who could have enrolled this year. The resource situation reaches the absurd when, after blocking entry to these so-called "high income" veterans, VA issued a healthcare directive (VHA Directive 2003-003, January 17, 2003) to its workers directing them to send banned veterans to Community Social Work for assistance.

Looking at the 2004 budget, released last week, AMVETS notes that the Administration is proposing a $1.3 billion increase in VA health care. It is interesting to note that about 40 percent of the Administration's proposed increase, $525 million, comes directly from new premiums and co-payment increases for about 2 million veterans. The result of these proposals, according to VA, is to cause nearly 1.7 million currently enrolled veterans to leave the system, unwilling or unable to afford VA care.

To avoid implementation of the proposed exclusion of these veterans, The Independent Budget recommends the Senate provide $27.2 billion to fund VA medical care for fiscal year 2004, an increase of $1.9 over the Administration's request. We ask the Senate to recognize that the VA healthcare system is an excellent investment for America. However, it can only bring quality health care if it receives adequate funding.

We also ask Congress to recognize other potential challenges regarding veterans' health care in the potential for war with Iraq. By last year's count, about 15,000 VA employees are reservists subject to activation and 13,000 work in the healthcare system. In the event of war, it is likely that many more than the current number of approximately 400 VA employees will receive the call for active duty.

It is also important to clearly state that AMVETS along with its IB partners strongly supports shifting VA healthcare funding from discretionary funding to mandatory. Mandatory funding would give some certainty to healthcare services. VA facilities would not have to deal with the whimsy of discretionary funding, which has proven inconsistent and inadequate. We believe that mandatory funding would provide a comprehensive solution to the current funding problem. Once healthcare

funding matches the actual average cost of care for veterans enrolled in the system, with annual indexing for inflation, the VA can fulfill its mission.

THE NATIONAL CEMETERY ADMINISTRATION

Before I address budget recommendations for the National Cemetery Administration, which is AMVETS' primary responsibility in the development of The Independent Budget, I would like members of the Committee to know that AMVETS fully appreciates the strong leadership and continuing support demonstrated by the Senate Veterans' Affairs Committee. AMVETS is truly grateful to those who serve on this important committee. Through your work, you represent the veteran's voice and you have distinguished yourselves as willing to lead the country in addressing issues important to veterans and their families.

Since its establishment, the National Cemetery Administration (NCA) has provided the highest standards of service to veterans and eligible family members in the system's 120 national cemeteries.

Currently, the National Cemetery Administration maintains more than 2.5 million gravesites on 13,850 acres of cemetery land. Progress is underway at several sites around the country to complete construction of new national cemeteries, including Atlanta, GA; Detroit, MI; Miami, FL; Oklahoma City, OK; Pittsburgh, PA; and Sacramento, CA. Clearly, without the strong commitment of the Senate and its authorizing and appropriations committees, VA would likely fall short of burial space for millions of veterans and their eligible dependents.

The members of The Independent Budget are encouraged by the Administration's recommended increase in NCA resources for Fiscal Year 2004. However, it should be recognized that while the proposal addresses employment increases and equipment needs, it does not serve to address problems and deficiencies identified in the Study on Improvements to Veterans Cemeteries, a comprehensive report submitted in 2002 by VA to the Senate on conditions at each cemetery.

Volume 2 of the Study identifies over 900 projects for gravesite renovation, repair, upgrade, and maintenance. According to the Study, these project recommendations were made on the basis of the existing condition of each cemetery, after taking into account the cemetery's age, its burial activity, burial options and maintenance programs. The total estimated cost of completing these projects is nearly $280 million, according to the Study.

As any public facilities manager knows, failure to correct identified deficiencies in a timely fashion result in continued, often more rapid, deterioration of facilities and increasing costs related to necessary repair. The Independent Budget Veterans Service Organizations (IBVSOs) agree with this assessment and believe that the Senate needs to carefully consider this report to address the condition of NCA cemeteries and ensure they remain respectful settings for deceased veterans and visitors. We recommend that the Senate and VA work together to establish a timeline for funding these projects based on the severity of the problems.

Volume 3 of the Study describes veterans' cemeteries as national shrines saying that one of the most important elements of veterans' cemeteries is honoring the memory of America's brave men and women who served in the Armed Forces. "The commitment of the Nation," the report says, "as expressed by law, is to create and maintain national shrines, transcending the provisions of benefits to the individual—even long after the visits of families and loved ones."

Indeed, the Senate formally recognized veterans' cemeteries as national shrines in 1973 stating, "All national and other veterans' cemeteries—shall be considered national shrines as a tribute to our gallant dead." (P.L. 93-43:24 1003(c)) Moreover, many of the individual cemeteries within the system are steeped in history and the monuments, markers, grounds and related memorial tributes represent the very foundation of these United States. With this understanding, the grounds, including monuments and individual sites of interment, represent a national treasure that deserves to be protected and nurtured.

Unfortunately, despite NCA continued high standards of service and despite a true need to protect and nurture this national treasure, the system has and continues to be seriously challenged. The current and future needs of NCA require continued adequate funding to ensure that NCA remains a world-class, quality operation to honor veterans and recognize their contribution and service to the Nation.

The members of The Independent Budget recommend that the Senate provide $162 million in fiscal year 2004 for the operational requirements of NCA, the national Shrine initiative, and the backlog of repairs. We recommend your support for a budget consistent with NCA's growing demands and in concert with the respect due every man and woman who wears the uniform of the United States Armed

Forces. This is an increase of $17.8 million over the Administration's request for next year.

Clearly, the aging veteran population has created great demands on NCA operations. Primarily because of the mortality rate of World War II and Korean War veterans is increasing, as is the usage of burial services by Vietnam War Veterans, actuarial projections do not suggest a decline in these demands for many years. From current interment levels of 89,000 per year, the VA interment rate is projected to increase successively over the next several years peaking at 109,000 in the year 2008.

THE STATE CEMETERY GRANTS PROGRAM

For funding the State Cemetery Grants Program, the members of The Independent Budget recommend $37 million for the new fiscal year, an increase of $5 million over the Administration proposal. The State Cemetery Grants Program is an important complement to the NCA. It helps States establish gravesites for veterans in those areas where NCA cannot fully respond to the burial needs of veterans. The enactment of the Veterans Programs Enhancement Act of 1998 has made this program very active and attractive to the States.

Clearly, the enactment of the Veterans Benefits Improvements Act of 1998 has heightened the interest in the State cemetery grants program and increased participation of States in establishing fully equipped cemeteries for veterans. At the start of fiscal year 2003, the State cemetery grant program had eleven new cemeteries under design and thirteen new cemeteries in planning. In addition, the program had on hand 37 pre-applications for a total of $165 million. As before the 1998 legislative change, States remain totally responsible for operations and maintenance expenses to ensure conditions remain in a manner appropriate to honor the memory of veterans.

To augment support for veterans who desire burial in State facilities, members of The Independent Budget support increasing the plot allowance to $670 from the current level of $300. The plot allowance now covers less than 6 percent of funeral costs. Increasing the burial benefit to $670 would make the amount nearly proportional to the benefit paid in 1973. In addition, we firmly believe the plot allowance should be extended to all veterans who are eligible for burial in a national cemetery not solely those who served in wartime.

BURIAL BENEFITS

The IBVSOs also request the Senate review a series of burial benefits that have seriously eroded in value over the years. While these benefits were never intended to cover the full costs of burial, they now pay for only a fraction of what they covered in 1973, when they were initiated.

The IBVSOs recommend an increase in the service-connected benefits from $2,000 to $3,700. Prior to action in the last the Senate, increasing the amount $500, the benefit had been untouched since 1988. The request would restore the allowance to its original proportion of burial expense.

The IBVSOs recommend increasing the non-service-connected benefit from $300 to $1,135, bringing it back up to its original 22 percent coverage of funeral costs. This benefit was last adjusted in 1978, and today covers just 6 percent of burial expenses.

The IBVSOs also recommend that the Senate enact legislation to index these burial benefits for inflation to avoid their future erosion.

Mr. Chairman, this concludes my statement. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Chairman SPECTER. Thank you very much, Mr. Jones.

Well, as you men outlined the issues and the problems, there is no doubt that there is a shortfall here in what funds are available contrasted with what the needs are.

Mr. Wilkerson, I agree with you that there ought not to be a $250 enrollment fee. How do you evaluate Secretary Principi's contention that the VA can't sustain itself if it does not have that kind of a support?

Mr. WILKERSON. I believe he is probably right that without additional funding he is more or less forced to make a decision. Now,

whether or not the decision is right and fair is a matter that we can certainly differ on.

However, I think VA is not looking at the larger and perhaps more difficult issues of increasing its revenue sources and sort of business practices, if you will, in terms of providing additional revenue to them—I mean, a net increase in revenue that would permit them to continue to provide the level of service that veterans have come to expect.

Chairman SPECTER. Mr. Cullinan, among the division of the testimony, you focused on construction. I note that there has been an increase from $323 million to $525 million, which is a 62 percent increase. Where would you like to see the figure reside? That is the biggest increase in any category that the VA budget has.

Mr. CULLINAN. Mr. Chairman, a significant portion of that, though, is targeted for the CARES initiative, and that reduces the major construction portion back down to about $89 million. Therefore, we have urged the provision of $450 million for major construction.

That CARES initiative we strongly believe should be funded separately, both from the perspective of maintaining construction dollars and to keep a better eye on what CARES is actually doing.

Chairman SPECTER. Mr. Blake, focusing on the health care budget, you have emphasized, made the point that there is too much emphasis on collections. And as I look at increasing the outpatient co-payment and the increased pharmacy co-payments, et cetera, I agree with you that there is a very heavy emphasis on collections.

But is Secretary Principi crying wolf, or will he really be strangled if he doesn't get those additional funds?

Mr. BLAKE. Well, Mr. Chairman, as far as the collection is concerned, we have always maintained that it appears that when the budgets come out that the budget requests offset those collections, and we feel like those collections shouldn't be taken into account when considering the budget.

As far as the co-payments, PVA recently did a case study just to determine any members that we have that might be affected by the increase in the co-payments. And one of our members that actually works on our staff, based on the co-payments he pays now for different types of equipment and services and balanced against the proposal for the increase in the co-payments and the $250 enrollment fee, we projected that he would pay upwards of 200 percent more than what he currently pays by increasing those co-payments. And we just felt that that is ridiculous, I guess.

Chairman SPECTER. Mr. Surratt, what do you think about the idea of allowing veterans to come in just for pharmaceutical supplies without being enrolled for care? Do you think that would be a good policy, or do you think it would unduly burden the VA, as Secretary Principi testified?

Mr. SURRATT. Well, I think it has some pros and cons, Mr. Chairman.

Certainly if veterans could get their medical treatment privately, thereby saving VA money, and come only for the prescriptions, that would be of benefit to the VA. On the other hand, if so many veterans took advantage of that that VA spent more money than it would otherwise, then you could end up not saving money by that.

We are also concerned that VA would become for some veterans a provider of one service, pharmacy benefits, rather than a whole continuum of benefits.

So, quite frankly, we don't know, but we think there could be some serious problems with that.

Chairman SPECTER. Mr. Jones, you have had a lot of experience on Capitol Hill. We see the immovable object, the limitation of funds, and the irresistible force, the greater needs of veterans. And when enrollments of Category 8 veterans are suspended, it puts a lot of people in jeopardy. There may be some relief for those over 65. But those under 65 are going to be without services.

If you were chairman of this committee, what action plan would you undertake?

Mr. JONES. I would press as hard as I could, Mr. Chairman, to ensure that the correct priorities for spending were selected by the Senate. We believe that veterans' priorities rank very high on the list. And most of our freedoms that we cherish today come from the work of those who put their lives on the line, that honor should be respected by a country.

We know of leaders, over history, who have wisely said that failure to respect those who have served your Nation will soon result in a Nation no one will serve. I would put priorities first with veterans, whether it means tax policy or recommendation for billions of dollars of tax reductions, carve that down just $2 billion. Whether it is in any other policy of a multi-trillion budget, just $2 billion would resolve the problems in health care.

And I would move, as best I could, sir, as you are doing, to encourage the Senate to accept the priorities of the veterans first. And we appreciate the job you are doing.

Chairman SPECTER. Well, gentlemen, thank you. Thank you very much. You are invited to stay in touch as the year unfolds.

There have been consistent efforts to increase the Veterans budget over and above what has been proposed by the Administration, and I think Congressman Smith, chairman on the House side, has very serious reservations about the adequacy of the Administration's proposal, as I do.

At the same time, we are faced with very tight budget constraints overall, but your insights and your contacts with your members are really invaluable in showing us which way to go. So stay in touch.

Thank you all very much.

[Whereupon, at 5:36 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BOB GRAHAM,
U.S. SENATOR FROM FLORIDA

I welcome our witnesses to today's hearing, my first as Ranking Member of this Committee. Thank you, Senator Specter, for calling this hearing. I look forward to working with you, the other Members of this Committee, Secretary Principi, and the veterans' service organizations to meet the needs of the men and women who have served our Nation.

Today, we begin the long process of ensuring that the budget for Fiscal Year 2004 will allow VA to provide veterans with the care and benefits they have earned.

The Administration has extolled the proposed VA budget as a historic increase, beyond any expectation in the current economic climate. It has been touted as an increase of seven to 11 percent over last year's budget, depending on who is speaking and whose fuzzy math they are referring to. As we shape VA's budget for the next year, we must move beyond hopeful rhetoric and take an honest assessment of the needs of veterans.

When you strip away the new fees that are to be paid directly by veterans, the theoretical management efficiencies, and the sleight-of-hand accounting tricks, the Administration has asked for an appropriation that barely keeps pace with inflation.

It is disingenuous to boast of a historic increase that relies on an annual fee levied upon so-called "higher income" veterans—especially when "higher income" can mean as little as $24,000 a year. It is insulting to laud such an increase while barring some veterans from VA health care and more than doubling co-payments for others. And it is nothing short of contemptuous to deliberately drive veterans from the system and count that as savings.

When we enacted eligibility reform in 1996, we opened VA's doors to all veterans—and saw an increase in the number of veterans using the system by 54 percent. I see this increase as a tribute to the quality of care the agency provides. But it is also an indication of a shortcoming in our Nation's healthcare infrastructure—namely, the need for a meaningful Medicare prescription drug benefit and modernization of the Medicare program.

While VA's committed professionals are struggling to handle the increased patient load, they are doing it without a corresponding increase in resources. It is certainly not acceptable for a veteran to wait six months or more for vital health care. While I understand that Secretary Principi is striving to shrink waiting times for health care appointments, I fail to see how cutting off enrollment for new veterans will shorten the wait for those already enrolled.

One of my major concerns with the budget proposal is VA's reliance on collections to fund healthcare. It relies heavily on collections from those veterans who will now be barred or discouraged from seeking VA health care because of the Administration's fee increases and program restrictions. In addition, with VA's history surrounding collections from third-party payers, projections in the budget are highly optimistic. This means that the money taken directly from veterans' pockets will become even more critical to VA's operations. And this is not a viable long-term solution for meeting the needs of our veterans.

Restricting nursing home care for veterans in the future also will not solve the problems we face while caring for an aging veterans population. When Congress allowed VA to provide long-term care to a broader group of veterans, it intended for VA to develop non-institutional alternatives before cutting nursing home beds. Instead, VA has dragged its feet instead of creating alternatives. The consequence? Veterans, many who may become seriously ill and expect care, may have no place to turn.

Nowhere does this budget take into account the possibility that VA might be called upon to react to a disaster or to fulfill its Fourth Mission—caring for active duty military casualties. As this Nation prepares for the possibility of war, it is short-sighted to neglect this essential duty.

My concern is not just limited to VA's health care system spending, but also the benefits programs budget. Secretary Principi, I commend the progress that VA professionals have made in reducing the staggering backlog of claims over the past year. However, the Administration proposes a flat lined benefits budget—which is actually a decrease when accounting for inflation. Currently, veterans are forced to wait almost 200 days for VA to make a determination of eligibility for benefits—we all agree this is unacceptable. With the proposed funding level, I have trouble believing VA will be able to meet the ambitious target of 100 days for processing new claims.

As we begin discussing next year's budget proposal, there may be talk of scarce resources and meager increases as the best we can expect. Some believe that a $1.5 trillion tax cut should be our budget priority. But now is the time for us to fulfill our commitment to those who have served our Nation so honorably and they should be the priority. Ultimately, these budget issues are not a question of resources, they are a question of priorities.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL,
U.S. SENATOR FROM COLORADO

Thank you, Mr. Chairman.

I would like to welcome you, Mr. Secretary, and thank you for appearing before the committee today. I am looking forward to your testimony which will give us a better picture of how the Administration is going to address the serious issues facing the VA at this time. And, I also want to welcome the members of the VSOs who are going to comment on the budget today. I will be listening carefully to your testimony as you represent the opinions of veterans throughout the Nation.

Though I am encouraged with the overall FY 2004 funding increase, and particularly the increase for health care, I continue to be concerned that we find a way to take care of what will be an increasing number of elderly veterans. In my home State of Colorado, several clinics are no longer able to take new patients due to a lack of funding and providers, and many others have been asked to wait up to a year for care. I think we can all agree that one of our greatest national responsibilities is the welfare of our Nation's veterans. It is critical that we find a balanced way to make good on the promises to them.

Mr. Secretary, I appreciate your strong commitment to our veterans who have service-connected injuries and illnesses and have always admired you for stepping up to the plate to make the hard calls. However, the decisions to suspend enrollment for those who are not already on the priority ladder, and the proposals to add co-pays and enrollment fees for those not suffering from a military-related disability, will affect many veterans in my State of Colorado whose incomes are close to the cut-off for health care services. I will be listening carefully to the veterans who are meeting with me this month and I am looking forward to the testimony of the many veterans' organizations that will be testifying at the joint hearings during the next few weeks.

Speaking as a veteran, I believe we need to do all we can to serve those who have so honorably served us all.

Mr. Secretary, again, I thank you for being here. I look forward to hearing details of your budget proposal and how you plan to address these issues in an efficient and effective manner within the proposed budget. And, I look forward to working with you and the VSOs to make sure that our veterans receive the care they have been promised.

I thank the chair and look forward to today's testimony.

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA

Thank you, Mr. Chairman.

I welcome to this hearing my friend, Tony Principi, Secretary of the Department of Veterans Affairs, as well as Bob Roswell, Under Secretary for Health, Dan Cooper, Under Secretary for Benefits, Eric Benson, Acting Under Secretary for Memorial Affairs, Tim McClain, General Counsel and Bill Campbell, Assistant Secretary for Management. I am glad that you could all be here.

I also welcome the members of the various Veterans Service Organizations who will be testifying today.

As many of you have heard me say before, there is nothing that we do in this Committee that is more important than what we are doing today.

We are here to discuss an annual budget that is expected to run the second largest agency in the United States Government—an agency which millions of veterans turn to on a daily basis—an agency that for many, many veterans is a crucial part of their daily lives. This is true in my State of West Virginia, and I believe in all your home States, as well.

VA matters to veterans. During this budget process, we have an opportunity to show that veterans also matter to VA.

This afternoon, we will discuss the President's budget and whether it will provide adequate funding in FY 2004 for medical care, specialized services, research, timely compensation and pension decisions, our homeless programs, education and vocational rehabilitation, VA's vital role in homeland security, and much more.

And while we are doing this, we need to be ever mindful that we will, at the same time, be sending a message to our troops throughout the world about how well we, as a Nation, care for our veterans—and how prepared we are going to be to take care of today's heroes and heroines when they return home.

Some of us here will disagree about this proposed budget. Some may say that the President's budget request is adequate. I say that it clearly is not.

The President's budget proposal recommends that among other things, we increase prescription co-pays, bar Priority 8 veterans from enrolling, and restrict institutional long-term care benefits for our aging veterans. I say we should not.

Some may continue to publicly blame Congress for not appropriating enough money for VA. Others will note that in the last several years, Congress has appropriated more money for VA than the President requested.

But there is one place where I believe we can all come together.

We all believe in the mission of the VA and the importance of what this department does, or we wouldn't be here. And I think that we all can agree that without adequate funding—and proper use of that funding—VA cannot fulfill its mission to our Nation's veterans—past, present or future.

I hope that the results of this hearing, and the dialogue that follows, will be an FY 2004 budget of which we can all be proud—and a Department of Veterans Affairs that veterans across this country can rely on.

I look forward to working with my colleagues, with Secretary Principi and his capable staff, and with our valuable VSO membership in an effort to make that happen.

Thank you, again, for being here.

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